

3228

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | | | |
|--|----------------------------|--|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegheny</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegheny</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>Cumberland</u> | | <u>7 days</u> | | OR TOWN <u>La Vale</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>16 La Vale Street</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April 6 1955</u> | | | |
| <u>Samuel L. Ackerson</u> | | | | | | | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | 8. DATE OF BIRTH: <u>10/21/67</u> | 9. AGE last birthday: <u>87</u> yrs. | 10. IF UNDER 1 YEAR: Months Days Hours Min. | 11. BIRTHPLACE (State or foreign country): <u>New York</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Stone Mason Construction</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Walter Ackerson</u> | | | | 14. MOTHER'S MARRIAGE NAME: <u>Deborah (?)</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.): <u>NO</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.: <u>NONE</u> | | 17. INFORMANT & ADDRESS: <u>Patients Chart</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>congestive heart failure</u> | | | | | | <u>6 weeks</u> | |
| ANTECEDENT CAUSE (B) <u>coronary heart disease</u> | | | | | | <u>6 months</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>generalized arteriosclerosis</u> | | | | | | <u>1 year</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>4-3-1955</u> to <u>4-6-1955</u> that I last saw the deceased alive on <u>4-6-1955</u> , and that death occurred at <u>7:00</u> P.M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Channing</u> | | ADDRESS <u>57 Greene St.</u> | | DATE SIGNED <u>4-7-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 9, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Fawcett, M.D.</u> | | 24. FUNERAL DIRECTOR <u>William H. Kight</u> | | ADDRESS <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

VS. A11-10-51

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1955

BUREAU V. S.

3229

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

| | | | | | | | |
|--|-------------------------------|--|-------------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>12 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland, Md.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>604 Fairview Ave.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Francis Appold</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH <u>April 4, 1955</u> | | | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>5/26/99</u> | 9. AGE last birthday <u>55</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Queen City Brewing Co.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland Cumberland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME: <u>William Z. Appold</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Mary E. Stott</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-05-4976</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Cora Appold 604 Fairview Ave., Cumb.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>570.3</u> | | | | | | | |
| ANTECEDENT CAUSE (S): | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (A) <u>Generalized peritonitis</u> | | | | | | <u>6 d.</u> | |
| (B) <u>Perforation of sm. bowel (volvolus)</u> | | | | | | <u>6 d.</u> | |
| (C) <u>Volvolus</u> | | | | | | <u>10 d.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| <u>Cirrhosis of liver</u> | | | | | | <u>?</u> | |
| 19A. DATE OF OPERATION: <u>3-29-55</u> | | 19B. MAJOR FINDINGS OF OPERATION <u>Volvolus, perfor. of mid. (sm) bowel.</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>at work</u> | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Cumberland</u> | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4/4, 1955</u> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3/24, 1955</u> to <u>4/4, 1955</u> , that I last saw the deceased alive on <u>4/4, 1955</u> , and that death occurred at <u>10:25 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M. O. <u>Cumberland</u> | | ADDRESS <u>4-4-55</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>4/6/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 5, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. [Signature]</u> | | 24. FUNERAL DIRECTOR <u>Charles L. George</u> | | ADDRESS <u>Cumberland, Md.</u> | |

BUREAU V. S.

APR 13 1955

RECEIVED

3230

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | |
|---|-------------------------|--|---|--|---|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <u>Allegany</u> MARYLAND | | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Cumberland</u> | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Blvd. Apts. Kelly Blvd.</u> | | | STREET ADDRESS (If rural give location) <u>Blvd. Apts. Kelly Blvd.</u> | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | 4. DATE (Month) (Day) (Year) | | |
| CHARLES ARTHUR BIXLER | | | OF DEATH: April 28, 1955 | | |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: May 27, 1981 | 9. AGE last birthday: 73 yrs. | IF UNDER 1 YEAR: Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired telegraph oper.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Western Md. Rwy.</u> | 11. BIRTHPLACE (State or foreign country): <u>Singers Glen, Va.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> |
| 13. FATHER'S NAME: <u>Morgan J. Bixler</u> | | | 14. MOTHER'S MAIDEN NAME: <u>Catherine Fulk</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY No. <u>705-10-7843-A</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Katherine Bixler Blvd. Apts. Cumb.</u> |
| 18. MEDICAL CERTIFICATION | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary Disease</u> | | | | | <u>hours</u> |
| ANTECEDENT CAUSE (B) <u>Hypertension C.V. Disease</u> | | | | | <u>years</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Pericarditis Acute</u> | | | | | <u>years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan 1950</u> to <u>April 28, 1955</u> , that I last saw the deceased alive on <u>April 27, 1955</u> , and that death occurred at <u>about 11 PM</u> , from the causes and on the date stated above. | | | | | |
| SIGNATURE <u>B. M. Schudler</u> | | M. D. <u>4/29/55</u> | | DATE SIGNED <u>4/29/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5/2/55</u> | | NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Pauls Cem.</u> LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 29, 1955</u> | | REGISTRAR'S SIGNATURE <u>Winter R. Frank, M.D.</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>Charles L. George Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAY 3 1955

RECEIVED

3231

CERTIFICATE OF DEATH

Reg. Dist. No.

03219

7

| | | | | | | | |
|---|-----------------------------------|--|-------------------------------------|--|---------------------------|--|--------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>02</u> <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>15</u> days | | CITY (If outside corporate limits, write RURAL and give nearest town). <u>OR</u> <u>TOWN</u> <u>Cumberland, rural</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62</u> <u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Rt. #2, Baltimore Pike</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>E.</u> (Last) <u>Bramble</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April</u> <u>30</u> <u>19</u> <u>55</u> | | | |
| 5. SEX: <u>F</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>12/2/77</u> | 9. AGE last birthday <u>77</u> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 4 HRS. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country): <u>Md.</u> | |
| 13. FATHER'S NAME: <u>Deceased</u> <u>John T. Bramble</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Eliza Rice</u> <u>Deceased</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT & ADDRESS: <u>Pt's chart</u> | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>450.0</u> <u>Generalized atherosclerosis</u> | | | | | | <u>2 year</u> | |
| ANTECEDENT CAUSE (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Herpes Zoster</u> | | | | | | <u>2 weeks</u> | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>4-19</u> , 19 <u>55</u> , to <u>4-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-30</u> , 19 <u>55</u> , and that death occurred at <u>1</u> <u>45</u> P. M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Ralph W. Bacon</u> | | | | ADDRESS <u>M. D. Cumberland Md</u> | | DATE SIGNED <u>5-1-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>May 3, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Zion Memo. Park</u> | | LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>May 2, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 24. FUNERAL DIRECTOR <u>Louis Stein Inc.</u> | | ADDRESS <u>Cumb. Md</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3232

03220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 4

| | | | | | | | |
|---|-------------------|--|-------------------|---|----------------------------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | 02 | |
| TOWN <u>Cumberland</u> | | <u>52 Years</u> | | TOWN <u>907 Shades Lane, Cumberland, Md.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>907 Shades Lane</u> | | | | STREET ADDRESS (If rural, give location) <u>907 Shades Lane</u> | | | |
| 3. NAME OF DECEASED: | | (First) (Middle) (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| (Type or Print) <u>Curtis</u> | | <u>Russell</u> <u>Brant</u> | | <u>April 24</u> | | <u>19 55</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>Male</u> | <u>White</u> | <u>Married May 7, 1884</u> | <u>70</u> yrs. | <u>70</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Ret. Mch. B. & O. Railroad</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Flintstone Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Helper Henry W. Brant</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Lavina Deihl</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY No.: <u>705-05-5247</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Curtis R. Brant, Cumberland, Md.</u> | | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | No interval | |
| 420.1 Immediate cause | | (a) <u>Coronary Thrombosis</u> | | = | |
| Antecedent cause(s) | | (b) <u>Coronary Artery Disease</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | (c) <u>None of age</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| <u>Cumberland City Md</u> | | <u>Cumberland City Md</u> | | <u>Cumberland City Md</u> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE | | M. D. | | DATE SIGNED | |
| <u>J. Williams</u> | | | | <u>4/21/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>Apr. 26, 1955</u> | | <u>Trinity Luth. Cem.</u> | |
| LOCATION (City, town, or county) (State) | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Cumberland, Maryland</u> | | <u>John J. Hafer, Cumberland, Maryland</u> | | <u>Cumberland, Maryland</u> | |

BUREAU V. S.

APR 27 1955

RECEIVED

3233

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE MARYLAND | | COUNTY ALLEGANY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, | | LENGTH OF STAY (in this place) 4 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, RT. #1 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) BABY BOY George Randolph BRANT | | | | 4. DATE (Month) (Day) (Year) OF DEATH: APRIL 26 1955 | | | |
| 5. SEX: MALE | 6. COLOR OR RACE: WHITE | 7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH: APRIL 22, 1955 | 9. AGE last birthday: 3 yrs. | IF UNDER 1 YEAR: Months 4 Days 4 Hours 4 Min. | IF UNDER 24 HRS. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): MARYLAND, Cumberland | |
| 13. FATHER'S NAME: GLEN R. BRANT | | | | 14. MOTHER'S MAIDEN NAME: SUSAN DIEHL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Erythroblastosis Fetalis | | | | | | | |
| ANTECEDENT CAUSE (B) Rh Neg Sensitivity | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from .., 19...., to .., 19...., that I last saw the deceased alive on .., 19...., and that death occurred at 4:40A.M. , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS | | DATE SIGNED | | | |
| James B. Nuttall | | 23 Bedford St. | | 26 Apr 1955 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 4/26/55 | | Willow Cemetery | | Cumberland Md. | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| April 26, 1955 | | Walter R. Dantz, M.D. | | Louis Stein Jr. | | Cumberland, Md. | |

MARGIN RESERVED FOR BINTING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 9

3234

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | | | |
|--|--------------------------------|--|--|--|--|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cumberland, Maryland</u> TOWN <u>Memorial Hospital</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Avenue</u> | | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Grantsville, Maryland</u> TOWN <u>Grantsville, Maryland</u> STREET ADDRESS (If rural give location) | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Clark</u> <u>C.</u> <u>Butler</u> | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April 16,</u> <u>1955</u> | | |
| 5. SEX: <u>male</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>March 13, 1917</u> | | |
| 9. AGE last birthday: <u>38</u> yrs | | | 10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME: <u>Clark C. Butler</u> | | | 14. MOTHER'S MAIDEN NAME: <u>Mary Wilt</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>217-14-7500</u> | | |
| 17. INFORMANT & ADDRESS: <u>Memorial Hospital, Cumberland, Md.</u> | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 353.2 IMMEDIATE CAUSE (A) <u>Status Epilepticus</u> | | | <u>10 days</u> | | |
| ANTECEDENT CAUSE (B) <u>Cerebral Necrosis</u> | | | <u>7 days</u> | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19A. DATE OF OPERATION: | | | 19B. MAJOR FINDINGS OF OPERATION | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Apr 3, 1955</u> , to <u>Apr 16, 1955</u> , that I last saw the deceased alive on <u>Apr 16, 1955</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above. | | | | | |
| SIGNATURE <u>Clayton E. Surratt</u> | | ADDRESS <u>Cumberland</u> | | DATE SIGNED <u>4/18/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 19, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery, Grantsville, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 18, 1955</u> | | REGISTRAR'S SIGNATURE <u>Arator R. Trout, M.D.</u> | | 24. FUNERAL DIRECTOR <u>Wm Winterberg</u> ADDRESS <u>you personally</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 4 5

APR 19

1

3282

03223

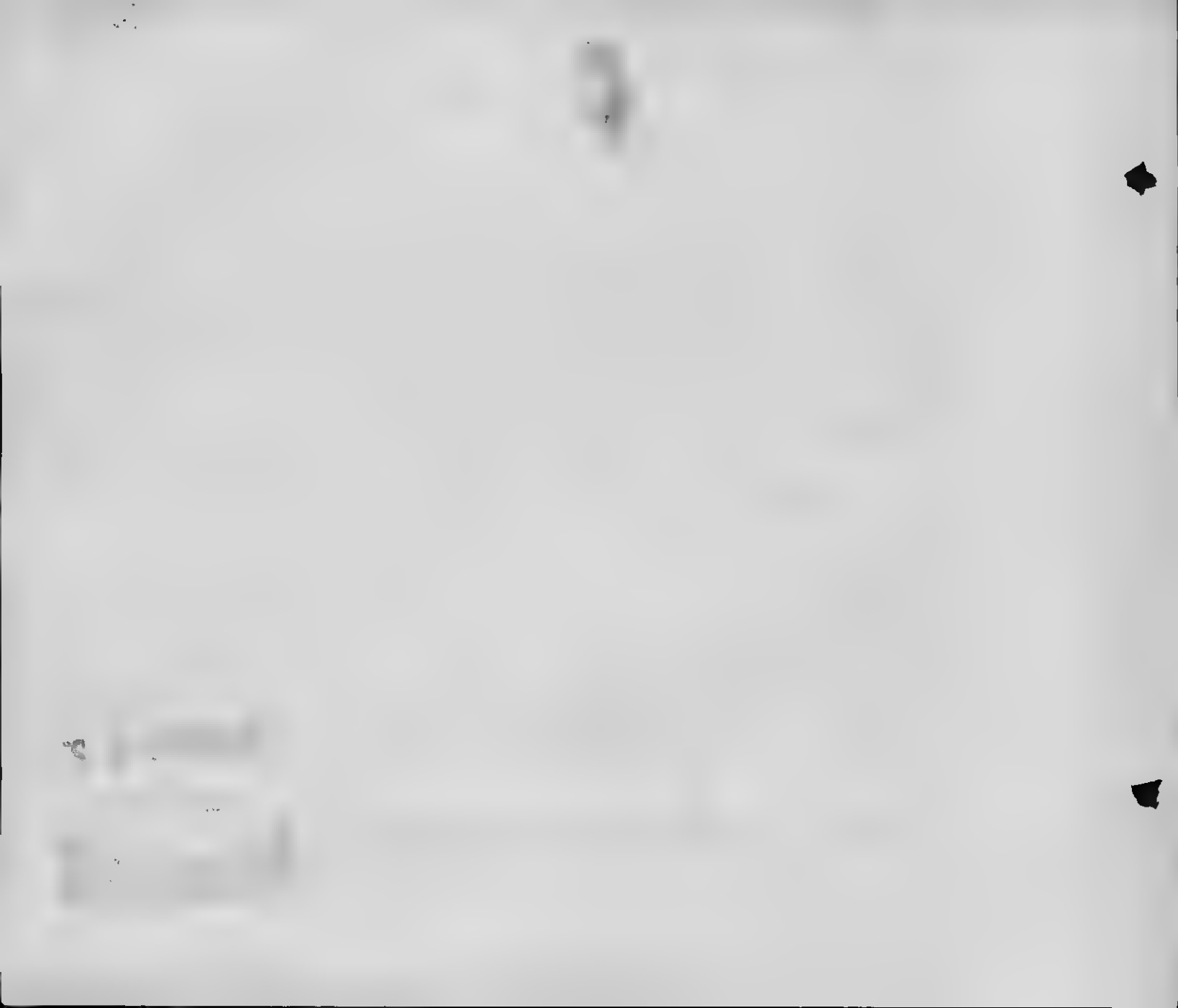
Reg. Dist. No. 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Frostburg</u> | | CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Frostburg</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u> | | STREET ADDRESS (If rural, give location) <u>248 1/2 Center St.</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Albert W. Capel</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 14 1955</u> | |
| 5. SEX: <u>male</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> | 8. DATE OF BIRTH: <u>Dec. 2-1885</u> |
| 9a. AGE last birthday: <u>69</u> yrs. | | 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work if retired): <u>laborer, City of Frostburg</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Oskaloosa, Iowa</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: <u>William Capel</u> | | 14. MOTHER'S MAIDEN NAME: <u>Eliza Shriver</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>220-10-2437</u> | |
| 17. INFORMANT & ADDRESS: <u>Miners Hospital records.</u> | | | |

| | | | |
|--|---|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | 18. MEDICAL CERTIFICATION | INTERVAL BETWEEN ONSET AND DEATH |
| <u>1. 2. 2. 2.</u> Immediate cause (a) <u>Acute cardiac dilatation</u> DUE TO | | Chronic myocarditis with hypertrophy. | ? |
| Antecedent cause(s) (b) <u>Chronic myocarditis with hypertrophy.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Impacted fracture of left humerus</u> | | | |
| 19a. DATE OF OPERATION: <u>19 days</u> | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, etc.) OF INJURY: <u>Back yard home Frostburg Allegany</u> | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>3-24-55-5 P. M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW AND INJURY OCCURRED: <u>fell against garage & fractured arm.</u> | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE: <u>H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <u>H.V. Deming M.D.</u> DATE SIGNED <u>4-15-1955</u> DEPUTY MEDICAL EXAMINER _____ ASSISTANT MEDICAL EXAM. _____ | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF: <u>4-17-1955</u> | NAME OF CEMETERY OR CREMATORY: <u>Fbg. Memorial Park</u> | LOCATION (City, town, or county) (State): <u>Frostburg Md.</u> |
| DATE REC'D BY LOCAL REG: <u>4-17-55</u> | REGISTRAR'S SIGNATURE: <u>Dr. Nancy A. Roe</u> | 24. FUNERAL DIRECTOR: <u>Joseph R. Durst, Frostburg, Md.</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3235

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-----------------------------------|--|--------------------------------------|--|---------------------------|---|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE W.VA. | | COUNTY Mineral | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND, MD. | | LENGTH OF STAY (in this place) 2 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PIEDMONT | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | STREET ADDRESS (If rural give location) 87 WEST HAMPSHIRE | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) RICHARD A CAREY | | | | 4. DATE (Month) (Day) (Year) OF DEATH: APRIL 4 1955 | | | |
| 5. SEX: MALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED | 8. DATE OF BIRTH 7-2, 1891 | 9. AGE last birthday 63 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CASHIER | | 10B. KIND OF BUSINESS OR INDUSTRY: W.VA. LIQUOR CONTROL COM. | | 11. BIRTHPLACE (State or foreign country): MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: JAMES CAREY | | | | 14. MOTHER'S MAIDEN NAME: MARY CAIN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Dissecting Aneurysm | | | | | | | |
| ANTECEDENT CAUSE (S) Generalized Arteriosclerosis | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 4-2-55 to 4-4-55 that I last saw the deceased alive on 4-3-55 , and that death occurred at 4:45 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE W. F. Williams | | M. D. Cumberland | | DATE SIGNED 4-4-55 | | MD | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | April 6, 1955 | | St. Peter's Cemetery | | Westernport, Maryland | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| April 4, 1955 | | Walter R. Davis, M.D. | | Redlock Funeral Home | | | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EVANS V. E.

APR 11 1901

10-10-01

DR. VAN ORMER

3236

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED. | |
| COUNTY ALLEGANY | MARYLAND | STATE MARYLAND | COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 11 HR. 55 MIN. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA VALE, near Cumberland, Rural | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) R. F. D. #1, La Vale | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) ISABEL L ouella CAWLEY | | 4. DATE OF DEATH: (Month) (Day) (Year) APRIL 28 1955 | |
| 5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED | 8. DATE OF BIRTH: MAY 17, 1920 |
| 9. AGE last birthday 34 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life.) Registered Nurse HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY: Cover Home | |
| 11. BIRTHPLACE (State or foreign country): PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: CHARLES CHRISTIAN | | 14. MOTHER'S MAIDEN NAME: ROSE SNYDER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W. II | | 16. SOCIAL SECURITY NO.: None | |
| 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) Cerebral Hemorrhage, spontaneous | | | 6 hours |
| ANTECEDENT CAUSE (S) DUE TO (B) arterial Hypertension | | | 8 years |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 18th 48 19th , to 28th 48 19th , that I last saw the deceased alive on 28th 48 19th , 1955, and that death occurred at 3:55A M, from the causes and on the date stated above. | | | |
| SIGNATURE W. A. V. A. Ormer | | ADDRESS Cumberland, Md. DATE SIGNED 29th 48 19th | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 4/30/55 | NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | LOCATION (City, town, or county) (State) Cumberland, Md. |
| DATE REC'D BY LOCAL REGISTRAR April 29, 1955 | REGISTRAR'S SIGNATURE Walter R. Frank, M.D. | 24. FUNERAL DIRECTOR H. Lee Silcox - Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BULEATI

1971

3288

03226

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

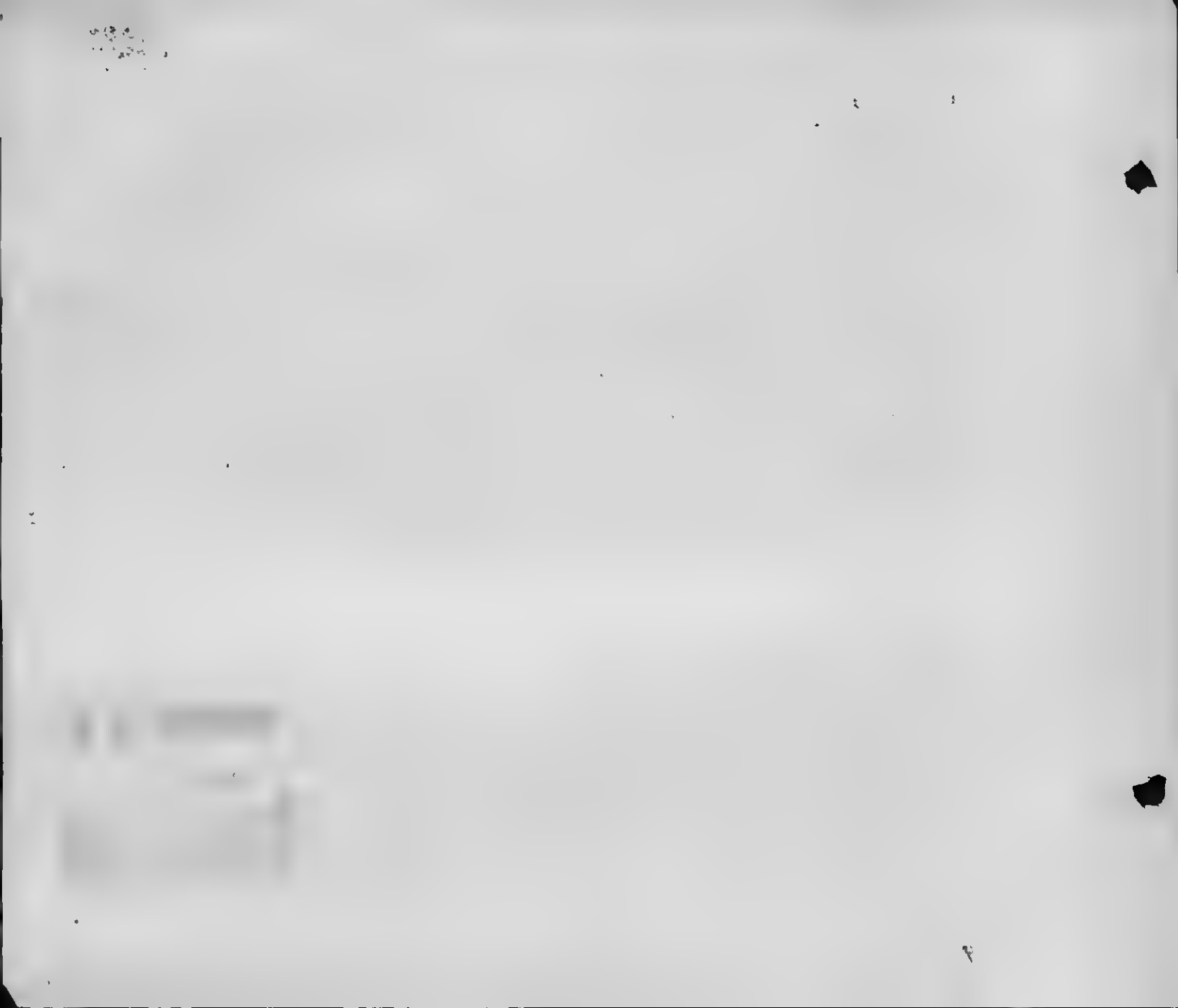
| | | | |
|--|----------------------------|--|------------------------------------|
| 1. PLACE OF DEATH: <u>Eckhart Md.</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegheny</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegheny</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Eckhart</u> | | CITY (If outside corporate limits write RURAL and give nearest town) <u>Eckhart</u> | |
| TOWN <u>Eckhart</u> | | TOWN <u>Eckhart</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Parkersburg Road</u> | | STREET ADDRESS (If rural, give location) <u>Parkersburg Road</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Edward Coddington, Jr.</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>4-18th 19 55</u> | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>3/22/1922</u> |
| 9. AGE last birthday: <u>33</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Ass't. Mgr. Credit Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Oakland, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: <u>George E. Coddington, Sr.</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mabel V. Wotring</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY No.: <u>215-14-6389</u> | |
| 17. INFORMANT & ADDRESS: <u>George E. Coddington, Sr. Oakland, Md.</u> | | | |

| | | |
|---|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Coronary Thrombosis</u> | | <u>4 hrs.</u> |
| Antecedent cause(s) (b) <u>—</u> | | <u>—</u> |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u> | | <u>—</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: <u>4-21-55</u> | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | 21c. (City or town) (County) (State) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>—</u> |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE <u>A. McPherson</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/18/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | DATE THEREOF: <u>4/21/55</u> | NAME OF CEMETERY OR CREMATORY: <u>Oakland Cemetery</u> |
| LOCATION (City, town, or county) (State): <u>Oakland, Md.</u> | 24. FUNERAL DIRECTOR: <u>Jacob Hafer, 23 E. Main, Frostburg, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>4-19-55</u> | REGISTRAR'S SIGNATURE: <u>Wm. Nancy A. Poe</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



3237

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | STATE <u>MD.</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Vale, Cumberland</u> STREET ADDRESS <u>R. F. D. #1, La Vale</u> | |
| 3. NAME OF DECEASED: (Type or Print) <u>Edward C. Coleman</u> | | 4. DATE (Month) (Day) (Year) OF DEATH <u>April, 28 1955</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH <u>July, 28, 1889</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Parking Lot Attendant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Barton, Md.</u> | |
| 13. FATHER'S NAME: <u>August Coleman</u> | | 14. MOTHER'S MAIDEN NAME: <u>Susan Miller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or both. If Yes, give war or dates) <u>Yes. World War #1</u> | | 16. SOCIAL SECURITY NO. <u>219 - 14 - 5828</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Allen Gardner, (Sister) Lonaconing, Md.</u> | | 18. MEDICAL CERTIFICATION | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | <u>6 hours</u> | |
| ANTECEDENT CAUSE (B) <u>Congestive Heart Failure</u> | | <u>2 mos.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>02/1/2</u> | | (C) <u>Coronary Heart Disease</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary Syphilis</u> | | <u>1 year.</u> | |
| 19A. DATE OF OPERATION: <u>May 1, 1955</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M.) | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>April 1955</u> to <u>28 Apr</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>55</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>George Eichhorn</u> | | DATE SIGNED <u>4-28-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>May 1, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Moscow, Md.</u> | |
| DATE RECEIVED BY LOCAL REGISTRAR <u>April 29, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Tank, M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>George Eichhorn</u> | | ADDRESS <u>Lonaconing, Md.</u> | |

MARGIN RESERVED FOR BINDING

4886

BOOK

Stl

AW

3238 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany Md. MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR and give nearest town) LENGTH OF STAY
 TOWN Cumberland, Maryland (in this place)
 HOSPITAL OR Decatur St. Cumberland, Md.
 INSTITUTION OR
 STREET ADDRESS Sacred Heart Hospital,

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Cumberland, Md.
 STREET ADDRESS (If rural give location) 532 Green St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HelenCollins

5. SEX.

6. COLOR OR RACE.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

4. DATE (Month) (Day) (Year)

OF

DEATH

April 1719 559. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Robert M. Collins

14. MOTHER'S MAIDEN NAME:

Anna Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT & ADDRESS:

Sister Mrs. Florence Denson, 532 Green St. City

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44.3X

IMMEDIATE CAUSE

(A)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

Hypertensive C.V. Disease(?)

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased

alive on , 19 , and that death occurred at

M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Louis Stein, Inc. Cumberland, Md.

MARGIN RESERVED FOR BINDING

11/20/70

3 A 000

3239

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 407 Columbia Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
 STREET ADDRESS (If rural give location) 407 Columbia Street

3. NAME OF DECEASED (Type or Print)

(First) Jane (Middle) (Last) Corfield

4. DATE (Month) (Day) (Year)
 OF DEATH April 16 19 55

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH

April 11, 1874

9. AGE last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS
81 yrs Months Days Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Montgomery Brown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO

None

17. INFORMANT & ADDRESS

Mrs. William Brady Cumberland, Md
Daughter

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

470.1

IMMEDIATE CAUSE

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

18. MEDICAL CERTIFICATION

(A) Cerebral Embolism

DUE TO

(B) Phlebotrombosis - left leg

DUE TO

(C) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

1 Da.

7 Da.

15 yr.

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

Generalized Arteriosclerosis

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory of INJURY street, office bldg, etc.) None

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) None

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY None M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 15, 1954 to April 16, 1955, that I last saw the deceased alive on April 16, 1955, and that death occurred at 8:05 A.M. from the causes and on the date stated above.

SIGNATURE

J. K. Hallinan MD

M. D.

ADDRESS

146 Bedford St. Cumberland, Md.

DATE SIGNED

4-16-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

April 18, 55

NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

April 16, 1955

REGISTRAR'S SIGNATURE

Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR

George Eichhorn

ADDRESS

Lonaconing, Md.

MARGIN RESERVED FOR BINDING

3240

CERTIFICATE OF DEATH

Reg. Dist. No. ... 4

Item 8. FilmG181 5-C-55 et

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH. COUNTY Allegany | | MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland | | COUNTY allegany | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Cumberland | | LENGTH OF STAY (in this place) 15 Yrs. | | CITY (If outside corporate limits, write RURAL and give nearest town) OR Cumberland | | TOWN Spring Gap X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat | | | | STREET ADDRESS (If rural, give location) | | 1 | |
| 3. NAME OF DECEASED (Type or Print) Jennie | | (First) (Middle) | | (Last) Crabtree | | 4. DATE OF DEATH (Month) April (Day) 27 (Year) 1955 | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | | 8. DATE OF BIRTH May 1, 1894 | |
| | | | | 9. AGE last birthday 68 yrs. | | 10. If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Pike Mills, Allegany Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Ross Crabtree | | | | 14. MOTHER'S MAIDEN NAME Martha Middleton Crabtree | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY No. None | | 17. INFORMANT AND ADDRESS Emma Meyers 114 Thomas St., Cumb., Md. | | | |

| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
|--|------------------------------|----------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 442X Immediate cause | (a) Chronic Myocarditis | ? |
| Antecedent cause(s) | (b) Chronic Nephritis | ? |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) General Arteriosclerosis | ? |
| II. OTHER SIGNIFICANT CONDITIONS | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | 15 yrs. |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? |

| | | | | | | |
|-------------------------------------|-------|-----------|---|-------------------------------|----------------------------------|-----------------------|
| 21. ACCIDENT SUICIDE HOMICIDE | | (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED | | HOW DID INJURY OCCUR? |
| OF | | | | While at | Not While | |
| INJURY | | | m. | Work <input type="checkbox"/> | At work <input type="checkbox"/> | |

22. I hereby certify that I attended the deceased from Jan. 2, 1952, to Apr. 27, 1955, that I last saw the deceased alive on Apr. 26, 1955, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

SIGNATURE _____

(Degree or title)

ADDRESS

DATE SIGNED _____

| | | | | |
|--|-----------------------|-------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| Removal | April 29, 1955 | Oldtown Cemetery | Oldtown, Maryland | |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | ADDRESS |
| April 28, 1955 | Arnter R. Tawny, M.D. | | James F. Scarfelli, Cumberland, | " |

MARGIN RESERVED FOR BINDING

1

911

7-11-11
11-11-11

3241

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|-------------------|--|----------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Allegany CITY (If outside corporate limits write RURAL and give nearest town) TOWN Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary | | STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural give location) 212 South Lee Street | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) OF DEATH: | |
| (First) (Middle) (Last) (Type or Print) William Franklin Cramer | | April 15, 1955 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| Male | White | Widower | 9/10/1871 |
| 9. AGE last birthday | | 10. BIRTHPLACE (State or foreign country): | |
| 83 yrs | | Maryland Sharpsburg | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired City Laborer | | U. S. A. | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 14. MOTHER'S MAIDEN NAME: | |
| No | | Mary E. Moore | |
| 15. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| None | | Allegany County Infirmary | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 420.1 IMMEDIATE CAUSE | | | 12 hrs. |
| ANTECEDENT CAUSE (S): | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (A) DUE TO | | | |
| Coronary Thrombosis | | | |
| (B) DUE TO | | | |
| Chronic Myocarditis | | | |
| (C) DUE TO | | | |
| Cerebral Arteriosclerosis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| Bronchial Asthma | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Nov 11th, 1952, to Apr. 14th, 1955, that I last saw the deceased alive on Apr. 13th, 1955, and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE | | ADDRESS | |
| James H. Lee | | 47 Grove St | |
| M.D. | | DATE SIGNED | |
| | | 4-15-55 | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| Burial | | 4-18-1955 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Mountain View Cem. | | Sharpsburg, Md. | |
| DATE REC'D BY LOCAL REGISTRAR | | 24. FUNERAL DIRECTOR | |
| April 16, 1955 | | Charles L. George | |
| REGISTRAR'S SIGNATURE | | ADDRESS | |
| Walter R. Lang | | Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU OF

POST OFFICE

1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. STEGMAIER MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03232

3242 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY ALLEGANY | MARYLAND | STATE MARYLAND | COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL OR TOWN) CUMBERLAND | LENGTH OF STAY (If rural give location) 9 DAYS | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPTIAL | | STREET ADDRESS (If rural give location) 128 GREENE STREET | |
| 3. NAME OF DECEASED: (First) EDITH (Middle) M (Last) CRITES | | 4. DATE (Month) (Day) (Year) OF DEATH: APRIL 21 1955 | |
| 5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED | 8. DATE OF BIRTH: MARCH 4 1910 |
| 9. AGE last birthday 45 yrs | | 10. UNDER 1 YEAR Months Days Hours Min. | 11. BIRTHPLACE (State or foreign country): Maryland |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY: Hotel | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME: WILLIAM SWEENEY | | 14. MOTHER'S MAIDEN NAME: CLARA MARTZ | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No | | 16. SOCIAL SECURITY No. 214-05-6922 | |
| 17. INFORMANT & ADDRESS: Clyde Crites, Cumberland, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) Metastatic Carcinoma | | | 2 mos. |
| ANTECEDENT CAUSE (B) Carcinoma of cervix | | | 6 mos |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. | | | |
| (C) none | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: none | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 19B. MAJOR FINDINGS OF OPERATION | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from Jan. , 1955, to April , 1955, that I last saw the deceased alive on 21 April, 1955 , and that death occurred at 7:06 PM , from the causes and on the date stated above. | | | |
| SIGNATURE Jeanne E. Stegmaier | | ADDRESS M. D. Cumberland road, | DATE SIGNED 20 April 55 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF April. 24, 1955 | NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery |
| LOCATION (City, town, or county) (State) Cumberland, Md. | | | |
| DATE REC'D BY LOCAL REGISTRAR April 24, 1955 | | REGISTRAR'S SIGNATURE Walter R. Fawcett, M.D. | 24. FUNERAL DIRECTOR Charles L. George, Cumberland, Md. |

BUNYAN

MAY 3

3243

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland
 TOWN Cumberland LENGTH OF STAY (in this place) 40 years
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 708 Yale Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany
 CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland
 TOWN Cumberland
 STREET ADDRESS (If rural give location) 708 Yale Street

3. NAME OF DECEASED:

(First) Ernest (Middle) R. (Last) Davis

4 DATE (Month) (Day) (Year)
 OF DEATH April 8, 1955 19

5 SEX
Male

6 COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8 DATE OF BIRTH. Aug. 12, 1914

9 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 40 yrs Months Days Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B KIND OF BUSINESS OR INDUSTRY. B. & O. RR

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME:

Ernest F. Davis

14. MOTHER'S MAIDEN NAME:

Nannie P. Brewer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes

16 SOCIAL SECURITY NO. 214-07-6132

17 INFORMANT & ADDRESS Marguerite Davis, Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

451X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) DUE TO

(B) DUE TO

(C)

Dissecting Aneurysm

INTERVAL BETWEEN ONSET AND DEATH

Less than 14 hrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4. 7., 1955, to 4. 8., 1955, that I last saw the deceased alive on 4-7-1955, and that death occurred at 4:15 M, from the causes and on the date stated above.

SIGNATURE W. J. Williams

ADDRESS Cumberland

DATE SIGNED 4-8-55

MD

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF April 11, 1955

NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park

LOCATION (City, town, or county) Cumberland, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR April 9, 1955

REGISTRAR'S SIGNATURE Walter R. Gault, M.D.

24 FUNERAL DIRECTOR

ADDRESS William H. Kight, Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-11-11

11-11-11

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03234

CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | |
|--|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| X TOWN <u>Luxie</u> | <u>65 yrs</u> | OR TOWN <u>Luxie</u> | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>325 PRATT ST</u> | | STREET ADDRESS (If rural give location) | <u>325 PRATT ST</u> |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>Annie Elizabeth Dick</u> | | OF DEATH: <u>April 22</u> 19 <u>55</u> | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u> | 8. DATE OF BIRTH: <u>20 Sept 1867</u> |
| 9. AGE last birthday: <u>87</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Hancock, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME: <u>George Shoemaker</u> | | 14. MOTHER'S MAIDEN NAME: <u>Jusan Weller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>John Dick, Luxie, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 420.0 IMMEDIATE CAUSE | | (A) <u>Arteriosclerotic heart disease</u> | |
| ANTECEDENT CAUSE (S) | | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (B) | |
| | | DUE TO | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 21, 1955</u> , to <u>April 22, 1955</u> , that I last saw the deceased alive on <u>April 22, 1955</u> and that death occurred at <u>8:00</u> M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>James H. Wootton Jr.</u> | | M. D. <u>Richard W. Va</u> DATE SIGNED <u>April 23, 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| <u>Burial</u> | | <u>4-25-55</u> | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Philos Cemetery</u> | | <u>Westport Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| <u>Apr 25, 1955</u> | | <u>Miss Jean C. Kelly</u> | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>E. A. Basal</u> | | <u>Westport Md</u> | |

U. S. GOVERNMENT

1915

1915

3244 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY ALLEGANY MARYLAND
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN CUMBERLAND, MD. 138 days
 HOSPITAL OR Memorial Hospital
 INSTITUTION OR
 STREET ADDRESS Memorial Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN BARTON, MARYLAND Moscow
 ADDRESS Rt. #1, Barton
 (If rural give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)
 EVERETT DUCKWORTH

4. DATE (Month) (Day) (Year)
 OF DEATH April 11 19 55

5. SEX:

male white

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
 married

8. DATE OF BIRTH:

June 13 1879

9. AGE last birthday: 75 yrs
 IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life.)

Retired Miner

10B. KIND OF BUSINESS OR INDUSTRY:

Coal Mines

11. BIRTHPLACE (State or foreign country):

Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Harrison Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
 No

15. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS:

Memorial Hospital, Cumberland, Md.

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

197X

IMMEDIATE CAUSE

(A) DUE TO

Carcinoma of prostate

INTERVAL BETWEEN ONSET AND DEATH
 one yr.

ANTECEDENT CAUSE (S)

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

12-4-54

19B. MAJOR FINDINGS OF OPERATION

Obstruction of rectum & urethra

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1954, to 4-11-1955 that I last saw the deceased alive on 4-11-1955, and that death occurred at 6:10 PM from the causes and on the date stated above.

SIGNATURE

Dr. Mirkin md

ADDRESS

Cumberland md

DATE SIGNED

4-12-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

April 14, 1955

NAME OF CEMETERY OR CREMATORY

Lanell Hill Cemetery, Moscow, Maryland

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

April 13, 1955

REGISTRAR'S SIGNATURE

Walter R. Kautz, M.D.

24. FUNERAL DIRECTOR

George Eichhorn, Lonaconing, "

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. DEPARTMENT OF AGRICULTURE

SOIL CONSERVATION SERVICE



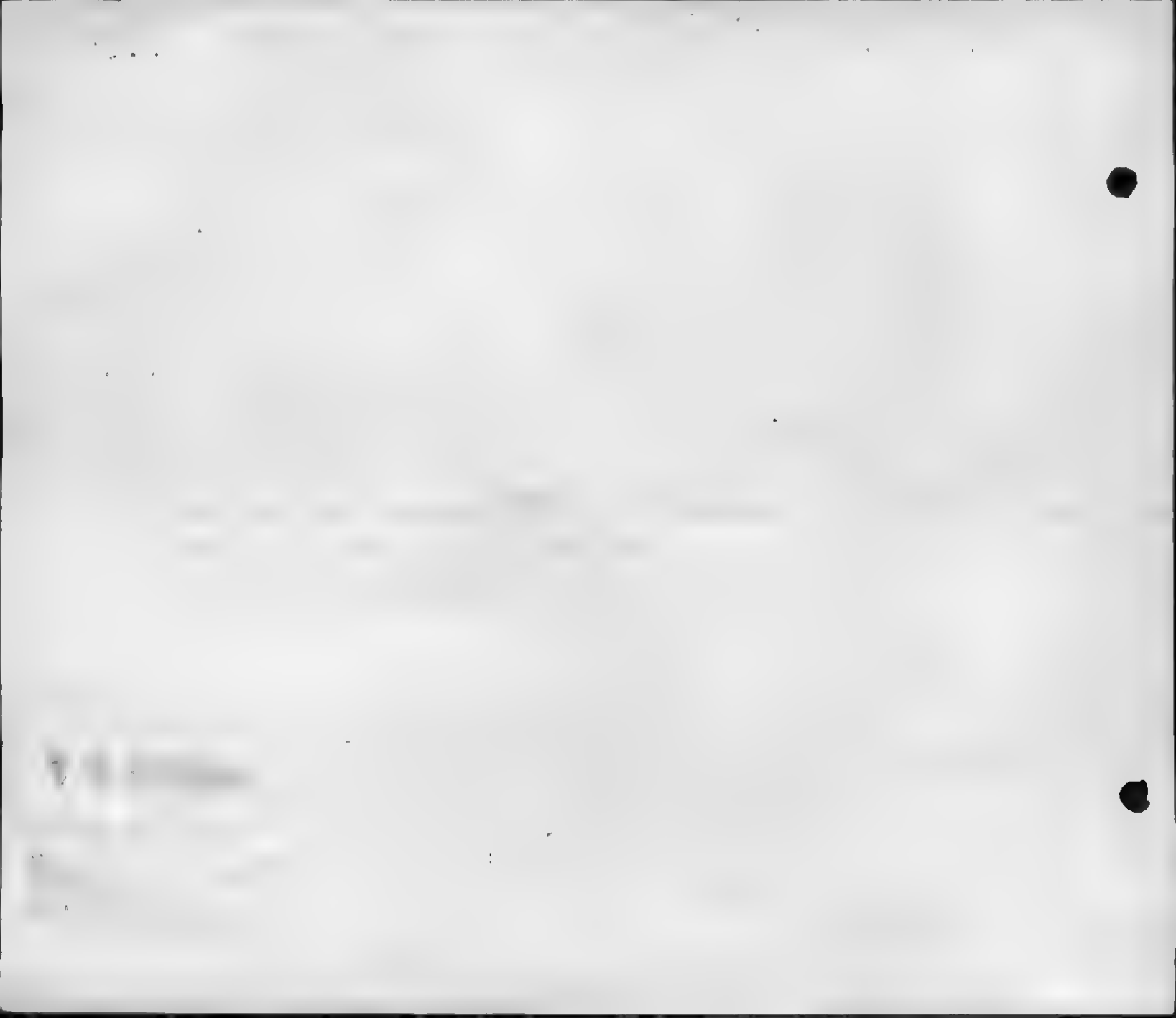
3245 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>ALLEGANY</u> CITY <u>CUMBERLAND</u> OR TOWN <u>CUMBERLAND</u> | MARYLAND LENGTH OF STAY (in this place) <u>10 DAYS</u> | STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> OR TOWN <u>CUMBERLAND</u> | COUNTY <u>ALLEGANY</u> (If rural give location) <u>805 COLUMBIA AVE.</u> |
| 3. NAME OF DECEASED: (First) <u>LOUIS</u> (Middle) <u>A</u> (Last) <u>FIRLIE</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 7</u> <u>1955</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u> | 8. DATE OF BIRTH: <u>SEPT 22, 1887</u> |
| 9. AGE last birthday: <u>67</u> yrs | | 10. AGE UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>George Construction Co</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>PENNSYLVANIA, New Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Joseph B. Firle</u> | | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-10-8765</u> | |
| 17. INFORMANT & ADDRESS: <u>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</u> | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | <u>11</u> | |
| ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u> | | <u>Large</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3:28</u> , 19 <u>55</u> to <u>4-7-1955</u> that I last saw the deceased alive on <u>4-7-1955</u> , and that death occurred at <u>7:45 P</u> M, from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. F. Wms.</u> | | DATE SIGNED <u>4-8-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 11, 55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Sts. Peters & Pauls</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| DATE READ BY LOCAL REGISTRAR <u>April 9, 1955</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>John J. Hafer, Cumberland, Maryland</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03237

3246

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|-------------------|--|----------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cumberland, Md.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland,</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | STREET ADDRESS (If rural give location) <u>112 N. Smallwood St.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) OF DEATH: | |
| (First) (Middle) (Last) <u>Bessie</u> <u>Cowdy</u> <u>Fisher</u> | | <u>April 27</u> <u>1955</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>July 17</u> <u>1881</u> |
| 9. AGE last birthday <u>73</u> yrs. | | 10. KIND OF BUSINESS OR INDUSTRY: | |
| | | <u>Housewife</u> <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Maryland</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| <u>James Graves</u> | | <u>Harriet Feaga</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| <u>No</u> | | <u>None</u> | |
| 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| <u>St.</u> <u>Husband G. Walter Fisher, 112 N. Smallwood</u> | | 19. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE <u>420.1</u> | | | |
| ANTECEDENT CAUSE (S) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| <u>(260X)</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| <u>Diabetes Mellitus</u> | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>4/21</u> , 19 <u>55</u> , to <u>4/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>55</u> , and that death occurred at <u>5:10</u> P. M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>Leo H. Hey</u> | | DATE SIGNED <u>4/28/55</u> | |
| ADDRESS <u>456 N. Centre St.</u> | | M. D. <u>456 N. Centre St.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| <u>Burial</u> | | <u>April 30, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>S. S. Peter & Paul Cem.</u> | | <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | 24. FUNERAL DIRECTOR | |
| <u>April 29, 1955</u> | | ADDRESS | |
| REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | <u>Charles L. George, Cumberland, Md.</u> | |

BUREAU

MAY 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3283

03238

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR TOWN | |
| TOWN <u>Weston</u> | | <u>3 days</u> | | TOWN <u>Annapolis</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>413 Spruce St.</u> | | | | STREET ADDRESS (If rural, give location) <u>183 Spruce St.</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (Type or Print) <u>Hilda Madeline Folk</u> | | | | (Month) (Day) (Year) <u>April 24 1955</u> | | | |
| 5. SEX: <u>Female</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | | 8. DATE OF BIRTH: <u>June 8, 1908</u> | |
| 9. AGE last birthday: <u>46</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Twist Tester Release Corp</u> | | 11. BIRTHPLACE (State or foreign country): <u>Westernport, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>James Patrick Sullivan</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Guy</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY No.: <u>210-10-8088</u> | | 17. INFORMANT & ADDRESS: <u>Gerold Folk, 183 Green St, Annapolis, Md.</u> | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | |
| 977X Immediate cause | | (a) <u>Hemorrhage from laceration of rt carotid artery</u> | | post mortem | |
| Antecedent cause(s) | | (b) <u>Dehydration of Mandibular</u> | | Tud | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | (c) <u>Dehydration of Mandibular</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-24-55-11P</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Self-inflicted</u> | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE <u>B.H. Williams</u> | | M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/24/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>4-27-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | |
| LOCATION (City, town, or county) (State) <u>Keyser, W. Va.</u> | | 24. FUNERAL DIRECTOR <u>E. S. Boal</u> | | ADDRESS <u>Weston, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>4-25-55</u> | | REGISTRAR'S SIGNATURE <u>Thomas C. Kelly</u> | | | |

2000

1000

1000

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03239

3247

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write OR and give nearest town)

RURAL LENGTH OF STAY (in this place)

TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

1101 Lexington Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits, write OR and give nearest town)

TOWN

STREET ADDRESS

1101 Lexington Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

James

H.

Foreman, Jr.

4. DATE OF DEATH:

(Month)

(Day)

(Year)

4

19

55

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

married

8. DATE OF BIRTH:

Feb. 5, 1867

9. AGE last birthday:

88

yrs.

IF UNDER 1 YEAR IF UNDER 21 YRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Fireman

10b. KIND OF BUSINESS OR INDUSTRY:

Tin Mill

11. BIRTHPLACE (State or foreign country)

Harpers Ferry, W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

James H. Foreman

14. MOTHER'S MAIDEN NAME:

Annie Giddie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

No

None

17. INFORMANT & ADDRESS:

Mrs. Margaret Davidson, Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 wks

5 yrs

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 5, 1955, to Apr 18, 1955, that I last saw the deceased alive on Apr 18, 1955, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 21, 1955

Walter R. Hank, M.D.

James F. Scarrelli, Cumberland, Md.

RECEIVED

APR 22 1955

RECEIVED

3248

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

TOWN CUMBERLAND

29 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

STREET ADDRESS (If rural give location)

504 PARK STREET

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

ARLINGTON

L.

FOSTER

SEX: MALE

COLOR OR RACE: WHITE

6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH:

OCT. 3 1896

4. DATE (Month) (Day) (Year)

OF DEATH: APRIL 19 1955

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

58 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life.)

10B. KIND OF BUSINESS OR INDUSTRY:

Night Watchman

Undergarment Factory

11. BIRTHPLACE (State or foreign country):

OHIO

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

JOHN FOSTER

14. MOTHER'S MAIDEN NAME:

MARY LUDWIG

15. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (Yes, no, or unk.) (If Yes, give year of service)

yes

WWI

16. SOCIAL SECURITY NO.

220-10-2583

17. INFORMANT & ADDRESS:

Records Memorial Hospital

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

(A)

Coronary Occlusion

ANTECEDENT CAUSE (B):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Hypertensive Cardio-Vascular Disease

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Pneumonia

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/21, 1955, to 4/19, 1955, that I last saw the deceased

alive on 4/17, 1955, and that death occurred at 9:10 AM from the causes and on the date stated above.

SIGNATURE

Les N. Ley Jr.

ADDRESS

M. D. 412 N. Centre St.

DATE SIGNED

4/19/55

23. BURIAL, CREMATION, DATE THEREOF

MOVIAL (SPECIFY)

4/21/55

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

St. Lukes Cemetery

Cumberland

MD

DATE REQ'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 20, 1955 Walter R. Muth, M.D.

Louis Stein Inc Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

100

Sir,

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| Dr. Simons | | | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | 03241 | |
|---|--|--|--|---|--|---|--|
| 3249 | | | | CERTIFICATE OF DEATH | | Reg. Dist. No. 4 | |
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>CUMBERLAND, MD.</u> | | <u>13 days</u> | | OR TOWN <u>CUMBERLAND, MARYLAND</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>Memorial Hospital</u> | | | | <u>437 Ascension St.,</u> | | | |
| <u>Memorial Avenue</u> | | | | | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>LILLIAN L. GATES</u> | | | | <u>APRIL 11 19 55</u> | | | |
| 5. SEX. | | 6. COLOR OR RACE. | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | | 8. DATE OF BIRTH: | |
| <u>female</u> | | <u>white</u> | | <u>widowed July 16, 1878</u> | | <u>76 yrs.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 9. AGE last birthday | | 11. BIRTHPLACE (State or foreign country). | |
| <u>Housewife</u> | | <u>Own home</u> | | <u>76</u> | | <u>Washington County, Md.</u> | |
| 13. FATHER'S NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| <u>James R. Norris</u> | | | | <u>U.S. A.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| <u>No</u> | | | | <u>None</u> | | | |
| 17. INFORMANT & ADDRESS: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Memorial Hospital, Cumberland, Md.</u> | | | | <u>Mary Creek</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | <u>2 year</u> | | | |
| 170X IMMEDIATE CAUSE | | (A) <u>Carcinoma Breast</u> | | | | | |
| ANTECEDENT CAUSE (B) | | DUE TO | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (B) DUE TO | | | | | |
| | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| M. | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>3/30</u> , 19 <u>55</u> , to <u>4/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>55</u> , and that death occurred at <u>10:28 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | DATE SIGNED <u>4/13/55</u> | | | |
| M.D. <u>Cumberland Md</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4/14/55</u> | | <u>Greenmount Cemetery</u> | | <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>April 13, 1955</u> | | <u>Walter R. Frank, M.D.</u> | | <u>Louis Stein, Inc.</u> | | <u>Cumberland, Md.</u> | |

38312

S. A. 100000

DR. HALLINAN

3250 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>ALLEGANY</u> | MARYLAND | STATE <u>MARYLAND</u> | COUNTY <u>ALLEGANY</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>CUMBERLAND</u> | <u>1 DAY</u> | OR TOWN <u>CUMBERLAND</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>MEMORIAL HOSPITAL</u> | | <u>201 SPRING STREET</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH: (Month) (Day) (Year) | |
| <u>THOMAS C. GORDON</u> | | <u>APRIL 17, 1955</u> | |
| 5. SEX: <u>MALE</u> | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u> | 8. DATE OF BIRTH: <u>FEBRUARY 5, 1906</u> |
| 9. AGE last birthday: <u>49</u> yrs. | | 10. AGE last birthday: <u>49</u> yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>CARMAN HELPER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>B. & O. R.R.CO.</u> | 11. BIRTHPLACE (State or foreign country): <u>MARYLAND, Cumberland</u> |
| 13. FATHER'S NAME: <u>CLIFFORD GORDON</u> | | 14. MOTHER'S MAIDEN NAME: <u>MARGARET WEISENMILLER</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>705-07-9668</u> | |
| 17. INFORMANT & ADDRESS: <u>MEMORIAL HOSPITAL - CUMBERLAND, MD.</u> | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 IMMEDIATE CAUSE | | <u>Coronary occlusion</u> | |
| ANTECEDENT CAUSE (S) | | <u>Coronary Heart Disease</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | <u>none</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | <u>none</u> | |
| 19A. DATE OF OPERATION: <u>none</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| <u>none</u> | | <u>none</u> | |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>APRIL 16, 1955</u> , to <u>APRIL 17, 1955</u> , that I last saw the deceased alive on <u>4-17, 1955</u> , and that death occurred at <u>3:30AM</u> , from the causes and on the date stated above. | | | |
| SIGNED: <u>J. L. Hallinan, M.D.</u> | | DATE SIGNED: <u>4-18-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Apr. 20, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 20, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Bantz, M.D.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>John J. Hafer, Cumberland, Md.</u> | | | |

MARGIN RESERVED FOR BINDING

RECEIVED

APR 22 1955

PT

CERTIFICATE OF DEATH

Reg. Dist. No. 4

3251

| | | | | | | | |
|--|-------------------|---|-------------------|---|-----------------|---|----------------|
| 1. PLACE OF DEATH. | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Pennsylvania</u> | | COUNTY <u>Bedford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Cumberland</u> | | <u>1 hr. 10 min.</u> | | TOWN <u>Bedford Valley</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | (If rural give location) | |
| <u>Sacred Heart Hospital</u> | | | | <u>Route #3</u> | | V | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH. | | | |
| <u>David M. Growden</u> | | | | <u>4-24-55</u> 19 <u>55</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| <u>M</u> | <u>W</u> | <u>Single</u> | <u>1-24-54</u> | <u>1 yr.</u> | <u>3</u> Months | <u>3</u> Days | <u>19</u> Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | <u>Infant</u> | | <u>Pa. Centerville</u> | | <u>U. S. A.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Alvin Growden</u> | | | | <u>Pearl Bosley</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service | | | | 16. SOCIAL SECURITY NO. | | | |
| <u>NO</u> | | | | <u>NONE</u> | | | |
| 17. INFORMANT & ADDRESS: | | | | <u>Chart Sacred Ht. Hosp. Cumberland</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) | | | | | | <u>Waterhouse-Friedrichsen's syndrome</u> 12/55 | |
| ANTECEDENT CAUSE (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc. | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While at work Not while at work | | 21F. HOW DID INJURY OCCUR? | | | |
| | | <u>4/24</u> | | <u>5:10 PM - 6:30 PM</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>4/24</u> , 19 <u>55</u> , to <u>4/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>55</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M. O. | | ADDRESS | | DATE SIGNED | |
| <u>Walter R. Krantz</u> | | <u>55 Green St.</u> | | <u>4/25/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>Apr. 26, 1955</u> | | <u>Fellowship Cemetery</u> | | <u>Centerville, Bedford Co. Pa.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>April 26, 1955</u> | | <u>Walter R. Krantz, M.D.</u> | | <u>John J. Hafer</u> | | <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30

SA 000000

1000

3290

CERTIFICATE OF DEATH

Reg. Dist. No. 8

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Lonaconing</u> | | <u>80yrs</u> | | TOWN <u>Lonaconing</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Charlestown Street</u> | | | | STREET ADDRESS (If rural give location) <u>Charlestown Street</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>DRUIE HACKER</u> | | | | <u>April, 9th 55</u> | | | |
| 5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | | | 8 DATE OF BIRTH: <u>Feb, 21, 1875</u> | | | |
| 9 AGE last birthday <u>80</u> yrs. | | | | 10 IF UNDER 1 YEAR: Months Days Hours Min. | | | |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housework</u> | | | | 10B KIND OF BUSINESS OR INDUSTRY: <u>Cwn Home</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Lonaconing, MD.</u> | | | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13 FATHER'S NAME: <u>Samuel Moses</u> | | | | 14 MOTHER'S MAIDEN NAME: <u>Rebecca Dawson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | |
| 17. INFORMANT & ADDRESS: <u>MRS. Thomas Clark, (Daughter)</u> | | | | <u>Lonaconing, Md.</u> | | | |
| 18 MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> | | | | | | <u>2d.</u> | |
| ANTECEDENT CAUSE (B) <u>Coronary Heart Disease</u> | | | | | | <u>1 year</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Atherosclerosis</u> | | | | | | <u>5 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | | 21C WHERE DID (City or town) INJURY OCCUR? (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3/28</u> , 19 <u>55</u> , to <u>4/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | DATE SIGNED <u>4-11-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>April, 12.55</u> | | <u>Oak Hill Cemetery</u> | | <u>Lonaconing, MD.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4-12-55</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>George Eichhorn, Lonaconing, MD.</u> | | | |

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3252

CERTIFICATE OF DEATH

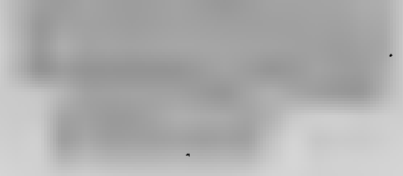
Reg. Dist. No. 4

| | | | | | |
|--|-----------------------------|--|---|---|---|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY Allegany | | | STATE Maryland COUNTY Allegany | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat Furnace Ext. | | | STREET ADDRESS (If rural give location) 950 Gay St. | | |
| 3. NAME OF DECEASED: (Type or Print) Charles Brace Hickie | | | 4. DATE (Month) (Day) (Year) OF DEATH: 4 22 1955 | | |
| 5. SEX: M. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M. | 8. DATE OF BIRTH: 5 17 1881 | | |
| 9. AGE last birthday 73 yrs. | | | 10. BIRTHPLACE (State or foreign country): Cumberland Md. | | |
| 11. BIRTHPLACE (State or foreign country): Cumberland Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: Charles Hickie | | | 14. MOTHER'S MAIDEN NAME: Susan Barnes | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.) NO (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. None | | |
| 17. INFORMANT & ADDRESS: Mrs Minnie Hickie, Cumberland, Md. | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | |
| IMMEDIATE CAUSE 4.2.1 | | | | | |
| ANTECEDENT CAUSE (S) | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | |
| (A) Chronic Myocarditis | | | | | |
| DUE TO | | | | | |
| (B) Cerebral Arteriosclerosis | | | | | |
| DUE TO | | | | | |
| (C) Osteo. arthritis (deforming), | | | | | |
| Alcoholic psychosis | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Mar 25 1955 to Apr 22 1955 that I last saw the deceased alive on Apr 22 1955 , and that death occurred at 12 P.M. from the causes and on the date stated above. | | | | | |
| SIGNATURE James B. Lee | | ADDRESS 49 Greene St. | | DATE SIGNED 4-28-55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF April 25 1955 | | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | |
| | | | | LOCATION (City, town, or county) (State) Cumberland Md. | |
| DATE REC'D BY LOCAL REGISTRAR April 24, 1955 | | REGISTRAR'S SIGNATURE Walter R. Trout, M.D. | | 24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

— 1 — C² 1/2

Items 180-184, 186-188, 190-192, 194-196, 198-200, 202-204, 206-208, 210-212, 214-216, 218-220, 222-224, 226-228, 230-232, 234-236, 238-240, 242-244, 246-248, 250-252, 254-256, 258-260, 262-264, 266-268, 270-272, 274-276, 278-280, 282-284, 286-288, 290-292, 294-296, 298-300, 302-304, 306-308, 310-312, 314-316, 318-320, 322-324, 326-328, 330-332, 334-336, 338-340, 342-344, 346-348, 350-352, 354-356, 358-360, 362-364, 366-368, 370-372, 374-376, 378-380, 382-384, 386-388, 390-392, 394-396, 398-400, 402-404, 406-408, 410-412, 414-416, 418-420, 422-424, 426-428, 430-432, 434-436, 438-440, 442-444, 446-448, 450-452, 454-456, 458-460, 462-464, 466-468, 470-472, 474-476, 478-480, 482-484, 486-488, 490-492, 494-496, 498-500, 502-504, 506-508, 510-512, 514-516, 518-520, 522-524, 526-528, 530-532, 534-536, 538-540, 542-544, 546-548, 550-552, 554-556, 558-560, 562-564, 566-568, 570-572, 574-576, 578-580, 582-584, 586-588, 590-592, 594-596, 598-600, 602-604, 606-608, 610-612, 614-616, 618-620, 622-624, 626-628, 630-632, 634-636, 638-640, 642-644, 646-648, 650-652, 654-656, 658-660, 662-664, 666-668, 670-672, 674-676, 678-680, 682-684, 686-688, 690-692, 694-696, 698-700, 702-704, 706-708, 710-712, 714-716, 718-720, 722-724, 726-728, 730-732, 734-736, 738-740, 742-744, 746-748, 750-752, 754-756, 758-760, 762-764, 766-768, 770-772, 774-776, 778-780, 782-784, 786-788, 790-792, 794-796, 798-800, 802-804, 806-808, 810-812, 814-816, 818-820, 822-824, 826-828, 830-832, 834-836, 838-840, 842-844, 846-848, 850-852, 854-856, 858-860, 862-864, 866-868, 870-872, 874-876, 878-880, 882-884, 886-888, 890-892, 894-896, 898-900, 902-904, 906-908, 910-912, 914-916, 918-920, 922-924, 926-928, 930-932, 934-936, 938-940, 942-944, 946-948, 950-952, 954-956, 958-960, 962-964, 966-968, 970-972, 974-976, 978-980, 982-984, 986-988, 990-992, 994-996, 998-1000, 1002-1004, 1006-1008, 1010-1012, 1014-1016, 1018-1020, 1022-1024, 1026-1028, 1030-1032, 1034-1036, 1038-1040, 1042-1044, 1046-1048, 1050-1052, 1054-1056, 1058-1060, 1062-1064, 1066-1068, 1070-1072, 1074-1076, 1078-1080, 1082-1084, 1086-1088, 1090-1092, 1094-1096, 1098-1100, 1102-1104, 1106-1108, 1110-1112, 1114-1116, 1118-1120, 1122-1124, 1126-1128, 1130-1132, 1134-1136, 1138-1140, 1142-1144, 1146-1148, 1150-1152, 1154-1156, 1158-1160, 1162-1164, 1166-1168, 1170-1172, 1174-1176, 1178-1180, 1182-1184, 1186-1188, 1190-1192, 1194-1196, 1198-1200, 1202-1204, 1206-1208, 1210-1212, 1214-1216, 1218-1220, 1222-1224, 1226-1228, 1230-1232, 1234-1236, 1238-1240, 1242-1244, 1246-1248, 1250-1252, 1254-1256, 1258-1260, 1262-1264, 1266-1268, 1270-1272, 1274-1276, 1278-1280, 1282-1284, 1286-1288, 1290-1292, 1294-1296, 1298-1300, 1302-1304, 1306-1308, 1310-1312, 1314-1316, 1318-1320, 1322-1324, 1326-1328, 1330-1332, 1334-1336, 1338-1340, 1342-1344, 1346-1348, 1350-1352, 1354-1356, 1358-1360, 1362-1364, 1366-1368, 1370-1372, 1374-1376, 1378-1380, 1382-1384, 1386-1388, 1390-1392, 1394-1396, 1398-1400, 1402-1404, 1406-1408, 1410-1412, 1414-1416, 1418-1420, 1422-1424, 1426-1428, 1430-1432, 1434-1436, 1438-1440, 1442-1444, 1446-1448, 1450-1452, 1454-1456, 1458-1460, 1462-1464, 1466-1468, 1470-1472, 1474-1476, 1478-1480, 1482-1484, 1486-1488, 1490-1492, 1494-1496, 1498-1500, 1502-1504, 1506-1508, 1510-1512, 1514-1516, 1518-1520, 1522-1524, 1526-1528, 1530-1532, 1534-1536, 1538-1540, 1542-1544, 1546-1548, 1550-1552, 1554-1556, 1558-1560, 1562-1564, 1566-1568, 1570-1572, 1574-1576, 1578-1580, 1582-1584, 1586-1588, 1590-1592, 1594-1596, 1598-1600, 1602-1604, 1606-1608, 1610-1612, 1614-1616, 1618-1620, 1622-1624, 1626-1628, 1630-1632, 1634-1636, 1638-1640, 1642-1644, 1646-1648, 1650-1652, 1654-1656, 1658-1660, 1662-1664, 1666-1668, 1670-1672, 1674-1676, 1678-1680, 1682-1684, 1686-1688, 1690-1692, 1694-1696, 1698-1700, 1702-1704, 1706-1708, 1710-1712, 1714-1716, 1718-1720, 1722-1724, 1726-1728, 1730-1732, 1734-1736, 1738-1740, 1742-1744, 1746-1748, 1750-1752, 1754-1756, 1758-1760, 1762-1764, 1766-1768, 1770-1772, 1774-1776, 1778-1780, 1782-1784, 1786-1788, 1790-1792, 1794-1796, 1798-1800, 1802-1804, 1806-1808, 1810-1812, 1814-1816, 1818-1820, 1822-1824, 1826-1828, 1830-1832, 1834-1836, 1838-1840, 1842-1844, 1846-1848, 1850-1852, 1854-1856, 1858-1860, 1862-1864, 1866-1868, 1870-1872, 1874-1876, 1878-1880, 1882-1884, 1886-1888, 1890-1892, 1894-1896, 1898-1900, 1902-1904, 1906-1908, 1910-1912, 1914-1916, 1918-1920, 1922-1924, 1926-1928, 1930-1932, 1934-1936, 1938-1940, 1942-1944, 1946-1948, 1950-1952, 1954-1956, 1958-1960, 1962-1964, 1966-1968, 1970-1972, 1974-1976, 1978-1980, 1982-1984, 1986-1988, 1990-1992, 1994-1996, 1998-2000, 2002-2004, 2006-2008, 2010-2012, 2014-2016, 2018-2020, 2022-2024, 2026-2028, 2030-2032, 2034-2036, 2038-2040, 2042-2044, 2046-2048, 2050-2052, 2054-2056, 2058-2060, 2062-2064, 2066-2068, 2070-2072, 2074-2076, 2078-2080, 2082-2084, 2086-2088, 2090-2092, 2094-2096, 2098-2100, 2102-2104, 2106-2108, 2110-2112, 2114-2116, 2118-2120, 2122-2124, 2126-2128, 2130-2132, 2134-2136, 2138-2140, 2142-2144, 2146-2148, 2150-2152, 2154-2156, 2158-2160, 2162-2164, 2166-2168, 2170-2172, 2174-2176, 2178-2180, 2182-2184, 2186-2188, 2190-2192, 2194-2196, 2198-2200, 2202-2204, 2206-2208, 2210-2212, 2214-2216, 2218-2220, 2222-2224, 2226-2228, 2230-2232, 2234-2236, 2238-2240, 2242-2244, 2246-2248, 2250-2252, 2254-2256, 2258-2260, 2262-2264, 2266-2268, 2270-2272, 2274-2276, 2278-2280, 2282-2284, 2286-2288, 2290-2292, 2294-2296, 2298-2300, 2302-2304, 2306-2308, 2310-2312, 2314-2316, 2318-2320, 2322-2324, 2326-2328, 2330-2332, 2334-2336, 2338-2340, 2342-2344, 2346-2348, 2350-2352, 2354-2356, 2358-2360, 2362-2364, 2366-2368, 2370-2372, 2374-2376, 2378-2380, 2382-2384, 2386-2388, 2390-2392, 2394-2396, 2398-2400, 2402-2404, 2406-2408, 2410-2412, 2414-2416, 2418-2420, 2422-2424, 2426-2428, 2430-2432, 2434-2436, 2438-2440, 2442-2444, 2446-2448, 2450-2452, 2454-2456, 2458-2460, 2462-2464, 2466-2468, 2470-2472, 2474-2476, 2478-2480, 2482-2484, 2486-2488, 2490-2492, 2494-2496, 2498-2500, 2502-2504, 2506-2508, 2510-2512, 2514-2516, 2518-2520, 2522-2524, 2526-2528, 2530-2532, 2534-2536, 2538-2540, 2542-2544, 2546-2548, 2550-2552, 2554-2556, 2558-2560, 2562-2564, 2566-2568, 2570-2572, 2574-2576, 2578-2580, 2582-2584, 2586-2588, 2590-2592, 2594-2596, 2598-2600, 2602-2604, 2606-2608, 2610-2612, 2614-2616, 2618-2620, 2622-2624, 2626-2628, 2630-2632, 2634-2636, 2638-2640, 2642-2644, 2646-2648, 2650-2652, 2654-2656, 2658-2660, 2662-2664, 2666-2668, 2670-2672, 2674-2676, 2678-2680, 2682-2684, 2686-2688, 2690-2692, 2694-2696, 2698-2700, 2702-2704, 2706-2708, 2710-2712, 2714-2716, 2718-2720, 2722-2724, 2726-2728, 2730-2732, 2734-2736, 2738-2740, 2742-2744, 2746-2748, 2750-2752, 2754-2756, 2758-2760, 2762-2764, 2766-2768, 2770-2772, 2774-2776, 2778-2780, 2782-2784, 2786-2788, 2790-2792, 2794-2796, 2798-2800, 2802-2804, 2806-2808, 2810-2812, 2814-2816, 2818-2820, 2822-2824, 2826-2828, 2830-2832, 2834-2836, 2838-2840, 2842-2844, 2846-2848, 2850-2852, 2854-2856, 2858-2860, 2862-2864, 2866-2868, 2870-2872, 2874-2876, 2878-2880, 2882-2884, 2886-2888, 2890-2892, 2894-2896, 2898-2900, 2902-2904, 2906-2908, 2910-2912, 2914-2916, 2918-2920, 2922-2924, 2926-2928, 2930-2932, 2934-2936, 2938-2940, 2942-2944, 2946-2948, 2950-2952, 2954-2956, 2958-2960, 2962-2964, 2966-2968, 2970-2972, 2974-2976, 2978-2980, 2982-2984, 2986-2988, 2990-2992, 2994-2996, 2998-3000, 3002-3004, 3006-3008, 3010-3012, 3014-3016, 3018-3020, 3022-3024, 3026-3028, 3030-3032, 3034-3036, 3038-3040, 3042-3044, 3046-3048, 3050-3052, 3054-3056, 3058-3060, 3062-3064, 3066-3068, 3070-3072, 3074-3076, 3078-3080, 3082-3084, 3086-3088, 3090-3092, 3094-3096, 3098-3100, 3102-3104, 3106-3108, 3110-3112, 3114-3116, 3118-3120, 3122-3124, 3126-3128, 3130-3132, 3134-3136, 3138-3140, 3142-3144, 3146-3148, 3150-3152, 3154-3156, 3158-3160, 3162-3164, 3166-3168, 3170-3172, 3174-3176, 3178-3180, 3182-3184, 3186-3188, 3190-3192, 3194-3196, 3198-3200, 3202-3204, 3206-3208, 3210-3212, 3214-3216, 3218-3220, 3222-3224, 3226-3228, 3230-3232, 3234-3236, 3238-3240, 3242-3244, 3246-3248, 3250-3252, 3254-3256, 3258-3260, 3262-3264, 3266-3268, 3270-3272, 3274-3276, 3278-3280, 3282-3284, 3286-3288, 3290-3292, 3294-3296, 3298-3300, 3302-3304, 3306-3308, 3310-3312, 3314-3316, 3318-3320, 3322-3324, 3326-3328, 3330-3332, 3334-3336, 3338-3340, 3342-3344, 3346-3348, 3350-3352, 3354-3356, 3358-3360, 3362-3364, 3366-3368, 3370-3372, 3374-3376, 3378-3380, 3382-3384, 3386-3388, 3390-3392, 3394-3396, 3398-3400, 3402-3404, 3406-3408, 3410-3412, 3414-3416, 3418-3420, 3422-3424, 3426-3428, 3430-3432, 3434-3436, 3438-3440, 3442-3444, 3446-3448, 3450-3452, 3454-3456, 3458-3460, 3462-3464, 3466-3468, 3470-3472, 3474-3476, 3478-3480, 3482-3484, 3486-3488, 3490-3492, 3494-3496, 3498-3500, 3502-3504, 3506-3508, 3510-3512, 3514-3516, 3518-3520, 3522-3524, 3526-3528, 3530-3532, 3534-3536, 3538-3540, 3542-3544, 3546-3548, 3550-3552, 3554-3556, 3558-3560, 3562-3564, 3566-3568, 3570-3572, 3574-3576, 3578-3580, 3582-3584, 3586-3588, 3590-3592, 3594-3596, 3598-3600, 3602-3604, 3606-3608, 3610-3612, 3614-3616, 3618-3620, 3622-3624, 3626-3628, 3630-3632, 3634-3636, 3638-3640, 3642-3644, 3646-3648, 3650-3652, 3654-3656, 3658-3660, 3662-3664, 3666-3668, 3670-3672, 3674-3676, 3678-3680, 3682-3684, 3686-3688, 3690-3692, 3694-3696, 3698-3700, 3702-3704, 3706-3708, 3710-3712, 3714-3716, 3718-3720, 3722-3724, 3726-3728, 3730-3732, 3734-3736, 3738-3740, 3742-3744, 3746-3748, 3750-3752, 3754-3756, 3758-3760, 3762-3764, 3766-3768, 3770-3772, 3774-3776, 3778-3780, 3782-3784, 3786-3788, 3790-3792, 3794-3796, 3798-3800, 3802-3804, 3806-3808, 3810-3812, 3814-3816, 3818-3820, 3822-3824, 3826-3828, 3830-3832, 3834-3836, 3838-3840, 3842-3844, 3846-3848, 3850-3852, 3854-3856, 3858-3860, 3862-3864, 3866-3868, 3870-3872, 3874-3876, 3878-3880, 3882-3884, 3886-3888, 3890-3892, 3894-3896, 3898-3900, 3902-3904, 3906-3908, 3910-3912, 3914-3916, 3918-3920, 3922-3924, 3926-3928, 3930-3932, 3934-3936, 3938-3940, 3942-3944, 3946-3948, 3950-3952, 3954-3956, 3958-3960, 3962-3964, 3966-3968, 3970-3972, 3974-3976, 3978-3980, 3982-3984, 3986-3988, 3990-3992, 3994-3996, 3998-4000, 4002-4004, 4006-4008, 4010-4012, 4014-4016, 4018-4020, 4022-4024, 4026-4028, 4030-4032, 4034-4036, 4038-4040, 4042-4044, 4046-4048, 4050-4052, 4054-4056, 4058-4060, 4062-4064, 4066-4068, 4070-4072, 4074-4076, 4078-4080, 4082-4084, 4086-4088, 4090-4092, 4094-4096, 4098-4100, 4102-4104, 4106-4108, 4110-4112, 4114-4116, 4118-4120, 4122-4124, 4126-4128, 4130-4132, 4134-4136, 4138-4140, 4142-4144, 4146-4148, 4150-4152, 4154-4156, 4158-4160, 4162-4164, 4166-4168, 4170-4172, 4174-4176, 4178-4180, 4182-4184, 4186-4188, 4190-4192, 4194-4196, 4198-4200, 4202-4204, 4206-4208, 4210-4212, 4214-4216, 4218-4220, 4222-4224, 4226-4228, 4230-4232, 4234-4236, 4238-4240, 4242-4244, 4246-4248, 4250-4252, 4254-4256, 4258-4260, 4262-4264, 4266-4268, 4270-4272, 4274-4276, 4278-4280, 4282-4284, 4286-4288, 4290-4292, 4294-4296, 4298-4300, 4302-4304, 4306-4308, 4310-4312, 4314-4316, 4318-4320, 4322-4324, 4326-4328, 4330-4332, 4334-4336, 4338-4340, 4342-4344, 4346-4348, 4350-4352, 4354-4356, 4358-4360, 4362-4364, 4366-4368, 4370-4372, 4374-4376, 4378-4380, 4382-4384, 4386-4388, 4390-4392, 4394-4396, 4398-4400, 4402-4404, 4406-4408, 4410-4412, 4414-4416, 4418-4420, 4422-4424, 4426-4428, 4430-4432, 4434-4436, 4438-4440, 4442-4444, 4446-4448, 4450-4452, 4454-4456, 4458-4460, 4462-4464, 4466-4468, 4470-4472, 4474-4476, 4478-4480, 4482-4484, 4486-4488, 4490-4492, 4494-4496, 4498-4500, 4502-4504, 4506-4508, 4510-4512, 4514-4516, 4518-4520, 4522-4524, 4526-4528, 4530-4532, 4534-4536, 4538-4540, 4542-4544, 4546-4548, 4550-4552, 4554-4556, 4558-4560, 4562-4564, 4566-4568, 4570-4572, 4574-4576, 4578-4580, 4582-4584, 4586-4588, 4590-4592, 4594-4596, 4598-4600, 4602-4604, 4606-4608, 4610-4612, 4614-4616, 4618-4620, 4622-4624, 4626-4628, 4630-4632, 4634-4636, 4638-4640, 4642-4644, 4646-4648, 4650-4652, 4654-4656, 4658-4660, 4662-4664, 4666-4668, 4670-4672, 4674-4676, 4678-4680, 4682-4684, 4686-4688, 4690-4692, 4694-4696, 4698-4700, 4702-4704, 4706-4708, 4710-4712, 4714-4716, 4718-4720, 4722-4724, 4726-4728, 4730-4732, 4734-4736, 4738-4740, 4742-4744, 4746-4748, 4750-4752, 4754-4756, 4758-4760, 4762-4764, 4766-4768, 4770-4772, 4774-4776, 4778-4780, 4782-4784, 4786-47



...

May 2

May 3



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3254

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03247

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------|--|---------------------------|---|-----------------|---|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>PENNSYLVANIA</u> COUNTY <u>Bedford</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| TOWN <u>CUMBERLAND</u> | | <u>30 DAYS</u> | | BEDFORD | | <u>75 x 2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) <u>BOX 432 605 S. Richards, S</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH | | | |
| <u>RUTH A HOLSOPPLE</u> | | | | <u>APRIL 10 1955</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>FEMALE</u> | <u>WHITE</u> | <u>DIVORCED</u> | <u>SEPTEMBER 22, 1917</u> | <u>37</u> yrs. | Months | Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>DIETICIAN</u> | | | | <u>BEDFORD MEMORIAL HOSP.</u> | | <u>BEDFORD, PA.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>IRA L. FOREMAN</u> | | | | <u>CORA C. DIBERT</u> | | | |
| 15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| | | | | <u>205-01-9626</u> | | <u>MEMORIAL HOSPITAL - CUMBERLAND, MD.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 17-X IMMEDIATE CAUSE | | | | | | | |
| ANTECEDENT CAUSE (S) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (A) <u>Carcinomatous thoracic cavity</u> | | | | | | | |
| DUE TO | | | | | | | |
| (B) <u>Carcinoma of breast</u> | | | | | | <u>Dec '53</u> | |
| DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| <u>Dec 53</u> | | | | <u>Carcinoma of breast</u> | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>3-2-1955</u> to <u>4-10-1955</u> that I last saw the deceased alive on <u>4-9-1955</u> , and that death occurred at <u>12:15 M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W.F. Williams</u> | | | | DATE SIGNED <u>4-10-55 ml</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL, (SPECIFY) | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | | | <u>4/13/55</u> | | <u>Bedford Memorial Cem. Bedford Penna.</u> | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| <u>Walter R. Jantz, M.D.</u> | | | | <u>Louis Geisel - Bedford, Penna.</u> | | | |

Handwritten signature

BURKAD V. S.

APR 15 1951

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

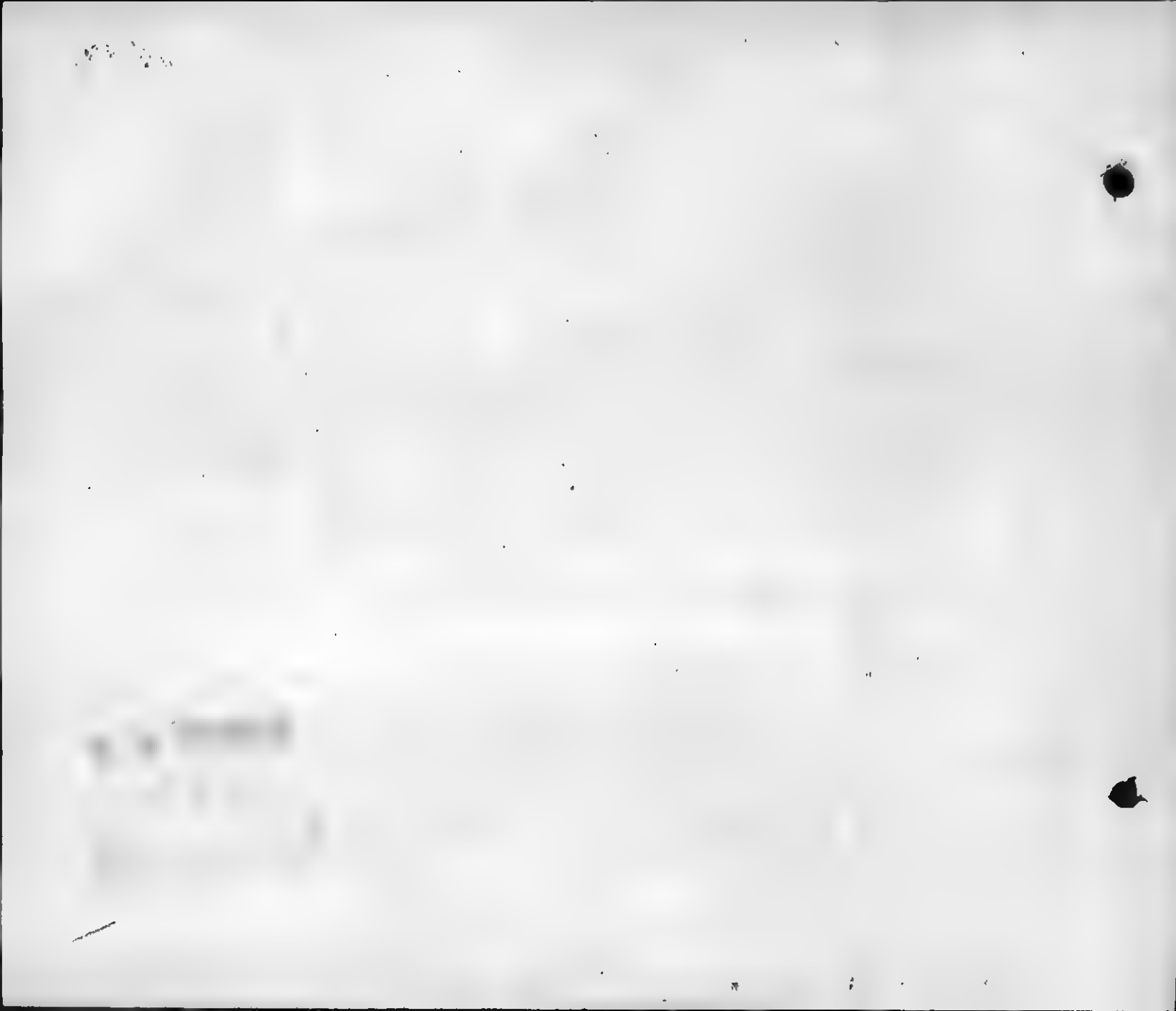
3291 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 103248

CERTIFICATE OF DEATH

Reg. Dist. No. 9

tem 9, ril-cl81 b-9-b5 et

| | | | | | | | |
|--|----------------------------|--|-------------------------------------|---|------------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Carles</u> | | <u>Life time</u> | | TOWN <u>Carles</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. L. No 1 Frothingham</u> | | | | STREET ADDRESS (If rural give location) <u>R. L. No 1 Frothingham, md</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Goldie</u> (Middle) <u>B.</u> (Last) <u>Hott</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April 22</u> 19 <u>55</u> | | | |
| 5. SEX: <u>F</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>Aug 3</u> 1907 | 9. AGE last birthday: <u>47</u> yrs | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House work</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country): <u>Carles, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Archie B. Holt</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Edith Stephenson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS: <u>Mrs Archie Holt (Mother)</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | <u>1 day</u> | |
| ANTECEDENT CAUSE (B) <u>Epilepsy, severe</u> | | | | | | <u>Since birth</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>4/21</u> , 19 <u>55</u> , to <u>4/22</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>55</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John B. Davis</u> | | | | ADDRESS <u>Carles, Md.</u> | | DATE SIGNED <u>4/28/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4-24-1955</u> | | <u>Frothingham Park</u> | | <u>Frothingham, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>4-28-55</u> | | <u>Mr. Harvey A. Rice</u> | | <u>Just</u> | | <u>Carles, Frothingham, Md.</u> | |



3255

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>ALLEGANY</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>ALLEGANY</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>02 CUMBERLAND</u> | | LENGTH OF STAY (in this place) <u>6 DAYS</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>02 CUMBERLAND</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60 MEMORIAL HOSPITAL MEMORIAL AVE.</u> | | | | STREET ADDRESS (If rural give location) <u>31 WEBER ST.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) | | | |
| (First) <u>HAROLD Jay</u> (Middle) <u>HOWARD</u> (Last) | | | | DEATH <u>APRIL 17</u> 19 <u>55</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 8. DATE OF BIRTH <u>JULY 17</u> 18 <u>83</u> | | 9. AGE last birthday <u>71</u> yrs | |
| | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | | | | 10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R.R. Postal Clerk</u> | | | | 11. BIRTHPLACE (State or foreign country): <u>VERMONT</u> | | | |
| 13. FATHER'S NAME: <u>GEORGE HOWARD</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>LUELLA CARPENTER</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u> | | | | 17. INFORMANT & ADDRESS: <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u> | | | |
| 18. SOCIAL SECURITY NO. <u>none</u> | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>422.1</u> | | | | (A) <u>Acute Anterior Myocardial Infarction</u> | | | |
| ANTECEDENT CAUSE (S) | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u> | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Mar 16</u> , 19 <u>55</u> , to <u>Apr 17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr 16</u> , 19 <u>55</u> , and that death occurred at <u>10:05AM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS <u>[Address]</u> | | DATE SIGNED <u>[Date]</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | DATE THEREOF <u>4/20/55</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u> | |
| | | | | | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 18, 1955</u> | | | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>H. Lee Silcox Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3256

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|----------------------------|--|----------------------------------|
| 1. PLACE OF DEATH: Allegany COUNTY MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital | | 2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Allengany STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural give location) 432 Grand Avenue | |
| 3. NAME OF DECEASED: (Type or Print) Mary Ellen Joyce | | 4. DATE (Month) (Day) (Year) OF DEATH: April 28 19 55 | |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 2-22-05 |
| 9. AGE last birthday 50 yrs. | | 10. BIRTHPLACE (State or foreign country): Maryland Cumberland | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY: | |
| 11. BIRTHPLACE (State or foreign country): Maryland Cumberland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: Thomas F. Joyce | | 14. MOTHER'S MAIDEN NAME: Ellen Rowan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS: Self Paul Joyce 432 Grand Ave. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) Congestive heart failure | | | 3 month |
| ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Chronic valvular heart disease, rheumatic | | | 3 years? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 27 Apr. 55, 19..., to 28 Apr. 1955, that I last saw the deceased alive on 28 Apr. 55, 19..., and that death occurred at 8 P. M. from the causes and on the date stated above. SIGNATURE h. A. Voz Dine ADDRESS M. D. Cumberland, Md. DATE SIGNED 30 Apr. 55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 5-2-55 | |
| NAME OF CEMETERY OR CREMATORY St. Partick Cem. | | LOCATION (City, town, or county) (State) Cumberland, Md. | |
| DATE REC'D BY LOCAL REGISTRAR April 30, 1955 | | REGISTRAR'S SIGNATURE Walter R. Frank, M.D. | |
| 24. FUNERAL DIRECTOR James F. Scarielli | | ADDRESS Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 3 1965

RECEIVED
MAY 3 1965

3257

CERTIFICATE OF DEATH

Reg. Dist. No.

4

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u> | LENGTH OF STAY (in this place) <u>24</u> hours | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | 2 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | STREET ADDRESS (If rural give location) <u>911 Louisanna Ave.</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Hallie</u> <u>Pattie</u> <u>Kesler</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April</u> <u>30</u> , 19 <u>55</u> | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | 8. DATE OF BIRTH: <u>June 10, 1889</u> |
| 9. AGE last birthday: <u>65</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Willowton, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Louis H. Davis</u> | | 14. MOTHER'S MAIDEN NAME: <u>Lillie B. Crowford</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO.: <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Pts Chart</u> <u>Ella Twigg 911 La. Ave</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Arterial Embolism (Femoral)</u> | | | <u>24 H</u> |
| ANTECEDENT CAUSE (B) <u>Vegetative Heart disease</u> | | | <u>2 yrs.</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>myocarditis</u> | | | <u>?</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>4. 29. 55</u> | | | 19B. MAJOR FINDINGS OF OPERATION <u>Femoral artery embolism</u> |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <u>4-29-55</u> to <u>4-30-55</u> , that I last saw the deceased alive on <u>4-30-55</u> , and that death occurred at <u>3:19</u> P. M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>B. C. Zimmerman</u> | | ADDRESS <u>M. C. Cumberland Md.</u> | |
| DATE SIGNED <u>5-1-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5-4-55</u> | NAME OF CEMETERY OR CREMATORY <u>St Peter and Paul Cem.</u> |
| LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>James F. Scarpelli</u> | | ADDRESS <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. AIR FORCE

2. 10. 1944

3258

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland,</u> | LENGTH OF STAY (In this place) <u>Life</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland,</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u> | | STREET ADDRESS (If rural give location) <u>79 Greene St.,</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>APPOLLONIA KRAFT</u> | | 4. DATE (Month) (Day) (Year) OF DEATH <u>April 23, 1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>July 22, 1869</u> |
| 9. AGE last birthday <u>85</u> | | 10. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>Andrew Kraft</u> | | 14. MOTHER'S MAIDEN NAME: <u>Sarah Ann Guthman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No,</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Miss Anna Kraft 79 Greene St., Cumb. Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE <u>440X</u> | | | |
| ANTECEDENT CAUSE (S): | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (A) <u>Hypertensive Cardiovascular Disease</u> | | | |
| (B) <u>Arteriosclerosis</u> | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>10.31, 1949</u> to <u>4.23, 1955</u> that I last saw the deceased alive on <u>4-12, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. H. Williams</u> | | DATE SIGNED <u>4-25-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cen.</u> | |
| DATE THEREOF <u>4/26/55</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 26, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Fandy, M.D.</u> | |
| | | 24. FUNERAL DIRECTOR <u>H. Wayne George</u> | |
| | | ADDRESS <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1/10/1908

1/10/1908

MARYLAND

STATE DEPARTMENT OF HEALTH

3259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH COUNTY <u>Allerany</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allerany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>434 Pennsylvania Ave.</u> | | STREET ADDRESS (If rural, give location) <u>434 Pennsylvania Avenue</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Eva</u> (First) <u>Bell</u> (Middle) <u>Lapp</u> (Last) | | 4. DATE OF DEATH <u>Apr. 18</u> (Month) <u>1955</u> (Year) | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>June 8, 1882</u> (Month) <u>1882</u> (Year) |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 9. AGE last birthday <u>72</u> yrs. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Frostburg, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew T. McLuckie</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Larue</u> | |
| 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. M. Yates, Cumberland, Maryland</u> | | | |

| | | |
|---|--------------------------------------|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>About 12 hrs.</u> |
| Immediate cause (a).... | <u>Coronary Thrombosis</u> | |
| Antecedent cause(s) (b).... | <u>Generalized Arterio Sclerosis</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).... | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

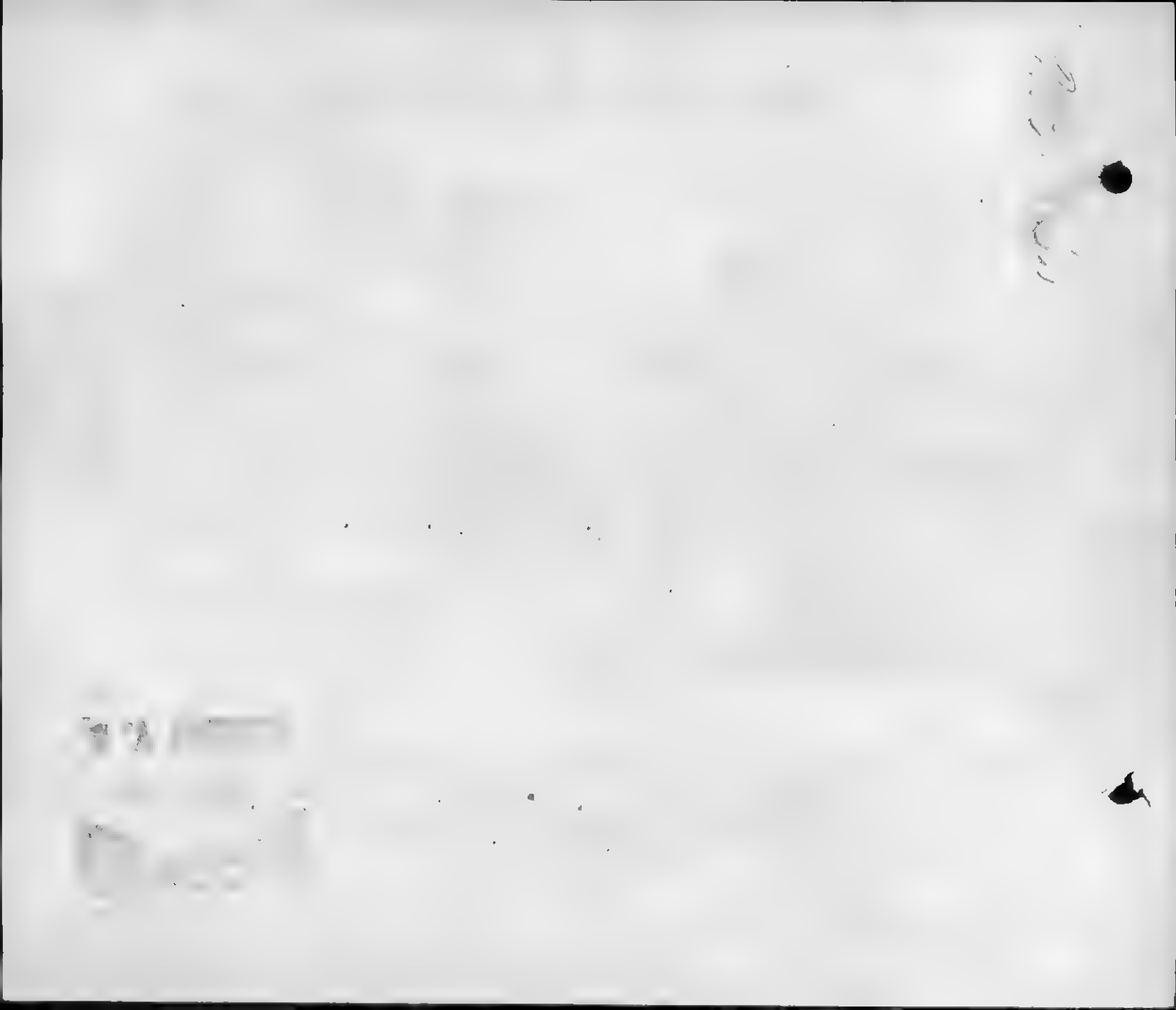
| | | |
|--|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from May, 1940 to 4. 18, 1955, that I last saw the deceased alive on 4-18-, 1955, and that death occurred at 4:45 P m., from the causes and on the date stated above.

SIGNATURE W. D. Williams ADDRESS Cumberland DATE SIGNED 4/18/55

| | | | |
|--|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE <u>April 21, 1955</u> | NAME OF CEMETERY OR CREMATORY <u>Hillcrest Bur. Park</u> | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> |
| DATE REC'D BY LOCAL REG. <u>April 21, 1955</u> | REGISTRAR'S SIGNATURE <u>Walter R. Smith, M.D.</u> | 24. FUNERAL DIRECTOR <u>John J. Hafer</u> | ADDRESS <u>Cumberland, Maryland</u> |

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

3284

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03254
Reg. Dist.

No. 9

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN | | 02 | |
| TOWN <u>Frostburg</u> | | 6 hrs. | | TOWN <u>Cumberland</u> | | 1 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 McCollough St.</u> | | | | STREET ADDRESS (If rural, give location) <u>104 East First St.</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (First) <u>Hettie</u> | | (Middle) | | (Last) <u>MacDonald</u> | | (Month) (Day) (Year) <u>April 9 1955</u> | |
| 5. SEX: <u>female</u> | | 6. COLOR OR RACE: <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u> | | 8. DATE OF BIRTH: <u>Nov. 11-1870</u> | |
| 9. AGE last birthday: <u>84</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Practical housewife</u> | | 11. BIRTHPLACE (State or foreign country): <u>Barton, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Phillip Keyes</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Elizabeth Varnick</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: <u>314-32-7339</u> | | 17. INFORMANT & ADDRESS: <u>MacDonald</u> (daughter) <u>Myrtle McDonald, Cumberland, Md.</u> | |

| | | |
|--|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH |
| 422.2 Immediate cause (a)..... <u>Acute myocardial failure</u> DUE TO <u>sudden</u> | | |
| Antecedent cause(s) (b)..... <u>Chronic myocarditis with hypertrophy</u> DUE TO <u>several years.</u> | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | |
| (c) | | |

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M.D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED April 11-1955

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>4-12-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
|---|--|-----------------------------|--|---|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--------------------------------|--|
| DATE REC'D BY LOCAL REG. <u>April 12, 1955</u> | | REGISTRAR'S SIGNATURE <u>Dr. Nancy A. Rose</u> | | 24. FUNERAL DIRECTOR <u>James F. Scarpelli</u> | | ADDRESS <u>Cumberland, Md.</u> | |
|--|--|--|--|--|--|--------------------------------|--|

4-13-55

ed.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03255

3260

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR TOWN) <u>Cumberland</u> | | LENGTH OF STAY (in this place) <u>2yrs. 4m. 10da.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | | 2 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat Furnace Ext.</u> | | | | STREET ADDRESS (If rural give location) <u>360 Frederick St.</u> | | 1 | |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH. | | | |
| <u>Sarah E. Mankamyer</u> | | | | <u>4 22 1955</u> | | | |
| 5. SEX: <u>F.</u> | | 6. COLOR OR RACE: <u>W.</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W.</u> | | 8. DATE OF BIRTH: <u>June 9 1877</u> | |
| 9. AGE last birthday <u>77</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>Glencoe, Somerset Co, Penna</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 12. IF UNDER 1 YEAR, Months Days Hours Min. | |
| 13. FATHER'S NAME: <u>Jacob Martz</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Sarah Shoemaker</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Elsie Sims, Cleveland, Ohio</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>422.1</u> | | | | | | | |
| ANTECEDENT CAUSE (S) <u>Chronic Nephritis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Cerebral Arteriosclerosis</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Transition</u> | | | | | | | |
| 19A. DATE OF OPERATION: <u>5 mo.</u> | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 19B. MAJOR FINDINGS OF OPERATION: <u>Severe psychosis & depression</u> | | | | | | 3 yrs. | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Apr. 12, 1955</u> to <u>Apr. 22 1955</u> that I last saw the deceased alive on <u>Apr. 22 1955</u> and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Jane E. McLean</u> | | M. D. <u>49 Green St.</u> | | DATE SIGNED <u>4-23-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 25 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Sand Patch, Somerset Co Pa.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 24, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Trautz, M.D.</u> | | 24. FUNERAL DIRECTOR <u>William H. Kight</u> | | ADDRESS <u>Cumberland, Md.</u> | |

5 A 000000

DR. FAW

3261

CERTIFICATE OF DEATH

Reg. Dist. No.

4.....

| | | | | | | | |
|--|-----------------------------------|---|--------------------------------------|--|---|--|--------------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY ALLEGANY | | MARYLAND | | STATE PENNA. | | COUNTY Bedford | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) 02 TOWN CUMBERLAND, MD. | | LENGTH OF STAY (in this place) 8 DAYS | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD, Rural | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 MEMORIAL HOSPITAL CUMBERLAND, MD. | | | | STREET ADDRESS (If rural give location) RT. # 3 | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) FLORIBEL Gray MARKWOOD | | | | 4. DATE OF DEATH: (Month) (Day) (Year) 4-24 1955 | | | |
| 5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED | 8. DATE OF BIRTH: 6-5-1905 | 9. AGE last birthday 49 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper at home | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): Lancaster, Ohio | |
| 13. FATHER'S NAME: WILLIAM E. GRAY | | | | 14. MOTHER'S MAIDEN NAME: IDA M. DIBBLE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE 175X | | | | | | Approx 2 yrs. | |
| ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | Approx 1 yr. | |
| (A) Carcinoma of ovary bilateral | | | | | | 3 months | |
| (B) metastasis to the liver | | | | | | | |
| (C) Terminal cachexia | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: Nov 1, 1954 | | | | 19B. MAJOR FINDINGS OF OPERATION Carcinoma of ovary bilateral | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | | | 21E. INJURY OCCURRED While <input checked="" type="checkbox"/> work Not while <input type="checkbox"/> at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Oct 28 , 1954 to Apr 24 , 1955, that I last saw the deceased alive on Apr 24 , 1955, and that death occurred at 4:40 P.M. , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Wm Fawcett Jr | | | | ADDRESS Cumberland | | DATE SIGNED md. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 4/27/55 | | NAME OF CEMETERY OR CREMATORY Mt. Rose Hill Cem. | | LOCATION (City, town, or county) (State) Coply Twn. Akron Ohio | |
| DATE REC'D BY LOCAL REGISTRAR April 25, 1955 | | REGISTRAR'S SIGNATURE Walter R. Jantzy, M.D. | | 24. FUNERAL DIRECTOR ADDRESS Louis Geisel- Bedford, Penna. | | | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 10 1953

RECEIVED

3262

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland, Md.

LENGTH OF STAY (In this place)

LifetimeHOSPITAL OR
INSTITUTION OR
STREET ADDRESSIn front of Home 217 Race St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Cumberland, Md.STREET
ADDRESS

(If rural give location)

217 Race St.3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

FrancisBasilMoreland

4. DATE (Month)

(Day)

(Year)

OF DEATH April 12, 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MWMarried Aug. 26, 188173

yrs

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Retired Grocery StoreOwn BusinessCumberland, Md.USA

13. FATHER'S NAME:

Wm. Moreland

14. MOTHER'S MAIDEN NAME:

Mary Shatzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-32-3272

17. INFORMANT & ADDRESS:

Francis B. Moreland Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

44 hrsCardiac arrestImmediateHypertension. Heart disease with angina 2 yearsarterial hypertension?

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1954, to 12 yrs., 1955 that I last saw the deceased alive on 11 yrs., 1955, and that death occurred at 4:35 A.M. from the causes and on the date stated above.

SIGNATURE

W. A. V. A. Oms

ADDRESS

M. D. Cumberland, Md.

DATE SIGNED

13 yrs. 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial4-15-55St Mary's Cem.Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 14, 1955 Walter R. Brang, M.D.James F. Scarpelli Cumberland Md

MARGIN RESERVED FOR BINDING

000000

000000 V. 3

1955

000000

3292

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03258

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED, | | | |
| COUNTY <u>Allegany</u> MARYLAND | | | | STATE <u>MD.</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write OR and give nearest town) <u>Lonaconing</u> RURAL LENGTH OF STAY (In this place) <u>63 yrs.</u> | | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lonaconing</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Church Street</u> | | | | STREET ADDRESS (If rural give location) <u>Church Street</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH | | | |
| <u>CATHERINE MURPHY</u> | | | | <u>April/6th. 1955</u> | | | |
| 5. SEX: <u>Female</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | | 8. DATE OF BIRTH: <u>Jan, 8th. 1892</u> | |
| 9. AGE last birthday <u>63</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | 11. BIRTHPLACE (State or foreign country): <u>Lonaconing, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Cornelius Murphy</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Mary Farrell</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Ye, give war or dates of service) <u>No</u> | | | | 16. MEDICAL CERTIFICATION | | | |
| 17. SOCIAL SECURITY NO. <u>None</u> | | | | 18. INFORMANT & ADDRESS: <u>Margaret Murphy (SISTER) Lonaconing, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE <u>420.0</u> | | | | <u>2 hrs</u> | | | |
| ANTECEDENT CAUSE (S) | | | | <u>4-5 hrs</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | | | <u>1-2 years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 1953 to <u>April</u> , 1955, that I last saw the deceased alive on <u>6 April</u> , 1955, and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. Richards</u> | | | | ADDRESS <u>Lonaconing, Md</u> DATE SIGNED <u>4/7/55</u> | | | |
| 23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 9</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u> | | LOCAT. ON (City, town, or county) (State) <u>Lonaconing, MD.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4-9-55</u> | | REGISTRAR'S SIGNATURE <u>Jannette M. Boal</u> | | 24. FUNERAL DIRECTOR <u>George Eichhorn</u> | | ADDRESS <u>Lonaconing, Md.</u> | |

1557

1557

1557

1557

3263

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|--|--|---------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Allegany County</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 TOWN Cumberland, Md</u> | LENGTH OF STAY (in this place) <u>17 days</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lonaconing, Md.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | STREET ADDRESS (If rural give location) <u>33 West Main St.</u> | |
| 3. NAME OF DECEASED: (Type or Print) | | 4. DATE (Month) (Day) (Year) | |
| (First) (Middle) (Last) <u>Mary Alice Neff</u> | | OF DEATH: <u>4-2-55</u> 19 <u>55</u> | |
| 5 SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH: <u>8-8-80</u> |
| 9. AGE last birthday <u>74</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>House Work</u>) | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u> | |
| 11 BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>William E. Clapp</u> | | 14. MOTHER'S MAIDEN NAME: <u>Ella Hedrick</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Miss Mary Neff (Daughter)</u> | | 18. MEDICAL CERTIFICATION <u>Lonaconing, Md.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Constrictive Heart Failure</u> | | <u>4 mo.</u> | |
| ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u> | | <u>12 yrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. HOW DID INJURY OCCUR? | |
| 21E. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>4-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>55</u> , and that death occurred at <u>8:55 P</u> M, from the causes and on the date stated above. | | | |
| SIGNATURE <u>[Signature]</u> | | DATE SIGNED <u>4-4-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 5, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Lonaconing, Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 5, 1955</u> | | REGISTRAR'S SIGNATURE <u>Winter R. Dantz, M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>George Eichhorn, Lonaconing, MD</u> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

RECEIVED

1951

1951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03260
Reg. Dist.

No. 4

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR TOWN | |
| TOWN <u>Cumberland</u> | | <u>30 yrs.</u> | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 Miltenburg Place</u> | | | | STREET ADDRESS (If rural, give location) <u>1 Miltenburg Place</u> | | | |
| 3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>William</u> (Last) <u>Randalls</u> | | | | 4. DATE OF DEATH (Month) <u>April</u> (Day) <u>7</u> (Year) <u>19 55</u> | | | |
| 5. SEX: <u>male</u> | | 6. COLOR OR RACE: <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u> | | 8. DATE OF BIRTH: <u>Sept. 24-1885</u> | |
| | | | | 9. AGE Last birthday: <u>69</u> yrs. | | IF UNDER 1 YEAR (Month) (Day) (Year) | |
| | | | | | | IF UNDER 24 HRS. (Month) (Day) (Year) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>blacksmith</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>B.C.R.Ny.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Keyser, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Benjamin Randalls</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Mary Sue Corbin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>705-05-4664</u> | | 17. INFORMANT & ADDRESS: (wife) <u>Minnie Ellsworth Randalls, City.</u> | | | |

| | | | |
|--|--|---|--|
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>gradual</u> <u>3 weeks</u> <u>?</u> |
| Immediate cause (a) <u>Asthenia</u> DUE TO <u>Malnutrition</u> Antecedent cause(s) (b) <u>Anorexia</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Chronic gastric ulcer.</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | |
| 21c. (City or town) (County) (State) | | 21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE <u>H.V. Deming M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>April 7-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u> | | DATE THEREOF <u>4/11/1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Greenmount Burial Park</u> | | LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| DATE REC'D BY LOCAL REG. <u>April 9, 1955</u> | | 24. FUNERAL DIRECTOR <u>Walter R. Parry, M.D.</u> ADDRESS <u>William H. Knight Cumberland Md</u> | |



DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03261

3265

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

COUNTY ALLEGANY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

LENGTH OF STAY
(in this place)
10 DAYSHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN CUMBERLAND

STREET ADDRESS (If rural give location)

333 MT. VIEW DRIVE

3. NAME OF
DECEASED
(Type or Print)

(First)

CHARLES

(Middle)

W

(Last)

RAYGOR

4. DATE (Month)

(Day)

(Year)

OF DEATH

APRIL 18

19 55

5. SEX
MALE6. COLOR OR RACE:
WHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify). WIDOWED

8. DATE OF BIRTH.

MARCH 26, 1877

78

yrs.

9. AGE last birthday IF UNDER 1 YEAR

IF UNDER 24 HRS.
Months Days Hours Mins.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Retired Conductor

10B. KIND OF BUSINESS OR INDUSTRY:

Railroad

11. BIRTHPLACE (State or foreign country)

Avalton, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

OLIVER RAYGOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Vincent Bargman (Daughter) City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C)

Chronic nephritis with uremia
arteriosclerosis
Diabetes mellitusINTERVAL BETWEEN
ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8, 1955, to 4-18, 1955, that I last saw the deceased

alive on 4-18, 1955 and that death occurred at 8:58 P M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

4-21-55

St. Marys Cem.

Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 21, 1955 Walter R. Taul, M.D. James F. Scarpelli, Cumberland, Maryland

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03262

Reg. Dist. No. 9

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH COUNTY Allegany | | MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland | | COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) 22 TOWN Frostburg | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Midland | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital | | | | STREET ADDRESS (If rural, give location) | | 1 | |
| 3. NAME OF DECEASED (Type or Print) | | (First) | | (Middle) | | (Last) | |
| Mary Ann | | Retallic | | | | | |
| 4. DATE OF DEATH | | (Month) | | (Day) | | (Year) | |
| April 6 | | 1955 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | |
| Female | | White | | Widowed | | July, 25, 1878 | |
| 9. AGE last birthday | | If under 1 year | | If under 24 hrs. | | If under 24 hrs. | |
| 81 | | Months | | Days | | Hours | |
| | | | | | | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housework | | Cwn Home | | Midland, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James A. Toll | | | | Stevenson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | | | | 16. SOCIAL SECURITY No. | | 17. INFORMANT | |
| No | | | | None | | Mrs. Isabella Morgan (Daughter) | |

| | | | |
|--|--|---|--|
| 18. MEDICAL CERTIFICATION | | Interval BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 156.1 | | ?? - | |
| Immediate cause | | (a) ADVANCED CARCINOMA OF LIVER | |
| Antecedent cause(s) | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | (b) _____ | |
| II. OTHER SIGNIFICANT CONDITIONS | | (c) _____ | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| NONE | | ✓ | |
| 20. AUTOPSY? | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | |
| NONE | | INJURY | |
| TIME (Month) (Day) (Year) (Hour) | | INJURY OCCURRED | |
| OF INJURY | | While at Work | |
| ✓ | | Not While At work | |
| | | ✓ | |
| HOW DID INJURY OCCUR? | | | |

22. I hereby certify that I attended the deceased from **3/30**, 19**55**, to **4/6**, 19**55**, that I last saw the deceased alive on **4/6**, 19**55**, and that death occurred at **2 P.** m., from the causes and on the date stated above.

| | | | | | |
|---|--|-------------------------------------|--|--|--|
| SIGNATURE | | ADDRESS | | DATE SIGNED | |
| Martin J. Rothstein | | 48 Broadway - Frostburg, Md. | | 4/7/55 | |
| 23. BURIAL, CREMATION REMOVAL (Specify) | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | April 9, 55 Memorial Park | | Frostburg, Md. | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| 4-9-55 | | Mrs. Nancy A. Roe | | George Eichhorn, Lonaconing, Md. | |

BUREAU V. S.

APR 1-1973

3266 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> LENGTH OF STAY (in this place) <u>4 yr. 1m. 18da.</u> TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat Furnace Ext.</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> STREET ADDRESS (If rural give location) <u>236 Williams St.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) | |
| (First) (Middle) (Last) <u>Emma</u> <u>Bexrode</u> | | DATE OF DEATH: <u>4</u> <u>22</u> <u>1955</u> | |
| 5. SEX: F. W. RACE: <u>W.</u> | | 6. DATE OF BIRTH: <u>Oct. 12, 1877</u> 77 yrs. | |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W.</u> | | 8. AGE last birthday: <u>77</u> yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Fairmont, West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>John Rollins</u> | | 14. MOTHER'S MAIDEN NAME: <u>Emma Wear</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Jas. W. Duffey, Baltimore, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Pulmonary Hypertension</u> | | | |
| ANTECEDENT CAUSE (S) (B) <u>Chronic Myocarditis</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Coronary Arteriosclerosis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u> | | | |
| 19A. DATE OF OPERATION: <u>Jan. 2, 1952</u> | | 19B. MAJOR FINDINGS OF OPERATION: <u>paranoid</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 2, 1952</u> to <u>Apr. 22, 1955</u> that I last saw the deceased alive on <u>Apr. 22, 1955</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>James B. McLean</u> | | DATE SIGNED <u>4-23-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Apr. 25, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Cap Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Paw Paw, West Virginia</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Apr. 25, 1955</u> | | 24. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Maryland</u> | |

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5. 10. 000000

5. 10. 000000

3267 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY ALLEGANY | MARYLAND | STATE MD. | COUNTY ALLEG. |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) CUMBERLAND | LENGTH OF STAY (in this place) 5 HRS. 20 MIN. | CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | 02 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural give location) 403 CENTRAL AVENUE | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) BABY GIRL | | 4. DATE (Month) (Day) (Year) APR. 24 1955 | |
| 5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH: APR. 24, 1955 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | | 10B. KIND OF BUSINESS OR INDUSTRY: None | 9. AGE last birthday: IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min. 5 20 |
| 11. BIRTHPLACE (State or foreign country): MD. Cumberland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME: RONALD RICE | | 14. MOTHER'S MAIDEN NAME: BARBARA COOK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE 77X Prematurity (5 mon. twin) | | | |
| (B) ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 4/24 , 1955 to 4/24 , 1955, that I last saw the deceased alive on 4/24 , 1955, and that death occurred at 11:25 P.M. the causes and on the date stated above. SIGNATURE W R Joyce Hodges ADDRESS Cumberland, Md. DATE SIGNED 4/25/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 4-26-55 | |
| NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | LOCATION (City, town, or county) (State) Cumberland, Md. | |
| DATE REC'D BY LOCAL REGISTRAR April 26, 1955 | | REGISTRAR'S SIGNATURE Walter R. Frank, M.D. | |
| 24. FUNERAL DIRECTOR James F. Scarpelli | | ADDRESS Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NY

3268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|-------------------|---|----------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY ALLEGANY MARYLAND | | STATE MD. COUNTY ALLEG. | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) CUMBERLAND | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) 403 CENTRAL AVENUE | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH: (Month) (Day) (Year) | |
| BABY GIRL | | APRIL 24 19 55 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: |
| FEMALE | WHITE | Single | APR. 24, 1955 |
| 9. AGE last birthday | | 10. BIRTHPLACE (State or foreign country): | |
| 5 yrs. | | MD. Cumberland | |
| 11. CITIZEN OF WHAT COUNTRY? | | 12. CITIZEN OF WHAT COUNTRY? | |
| USA | | USA | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| RONALD RICE | | BARBARA COOK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | None | |
| 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| MEMORIAL HOSPITAL | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE | | | |
| (B) ANTECEDENT CAUSE (S) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 4/24 , 19 55 , to 4/24 , 19 55 , that I last saw the deceased alive on 4/24 , 19 55 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. | | 22. I hereby certify that I attended the deceased from 4/24 , 19 55 , to 4/24 , 19 55 , that I last saw the deceased alive on 4/24 , 19 55 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. | |
| SIGNATURE W. Joyce Hodges | | ADDRESS Cumberland, Md. DATE SIGNED 4/25/55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| Burial | | 4-26-55 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Hillcrest Burial Park | | Cumberland, Md. | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| April 26, 1955 | | Walter R. Harty, M.D. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| James F. Scarpelli | | Cumberland, Md | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AT

3269

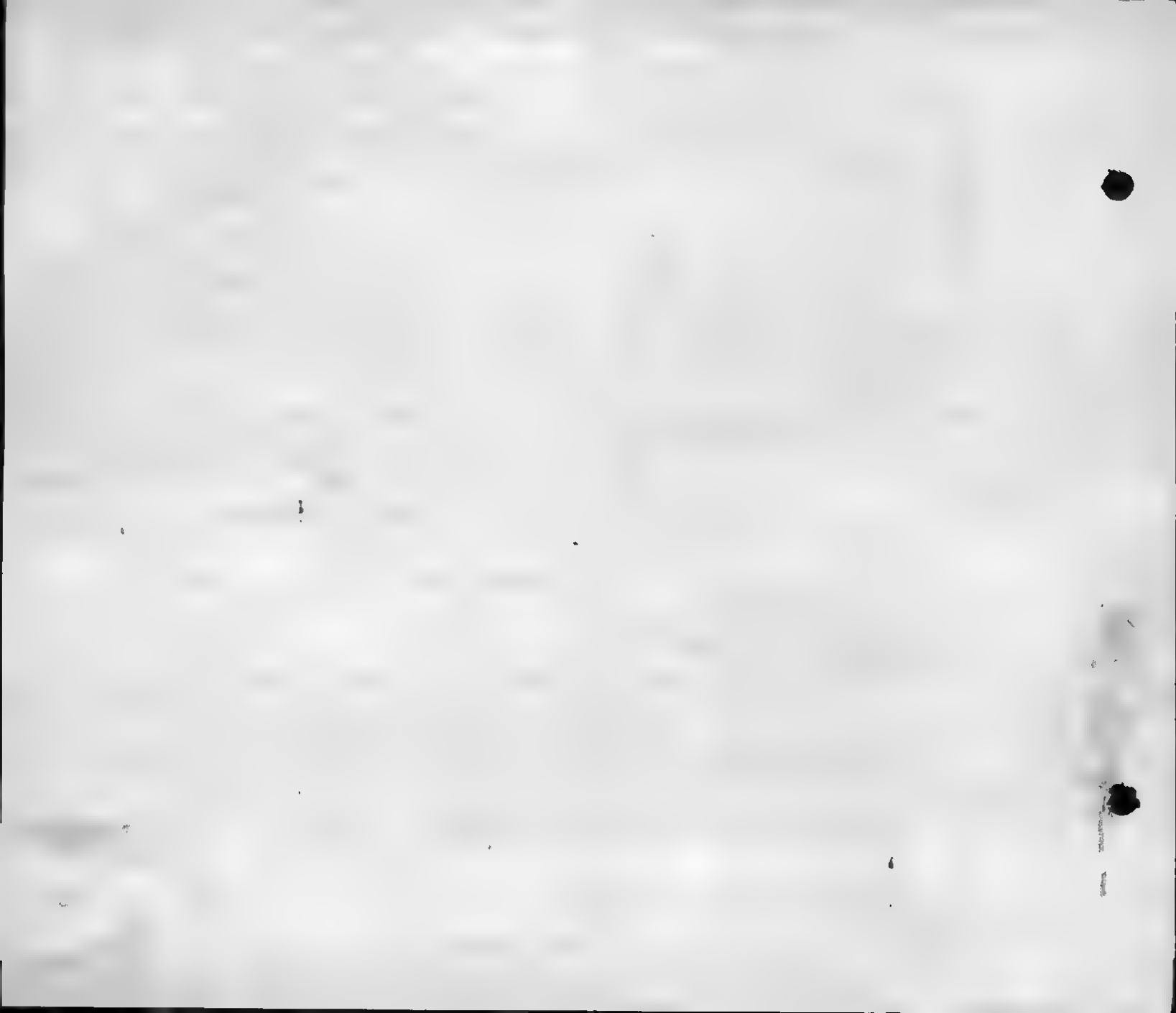
CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| | | | |
|---|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>Cumberland</u> | | OR TOWN <u>Cumberland</u> | 02 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | 1 |
| <u>417 Winner St.</u> | | <u>417 Winner St.</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| OF DEATH: (Type or Print) <u>WILLIAM ALEXANDER RILEY</u> | | OF DEATH: <u>April 14</u> <u>1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>May 12, 1864</u> |
| 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>90</u> yrs | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life or, if retired): <u>Retired Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own farm</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME: <u>Laban Riley</u> | | 14. MOTHER'S MAIDEN NAME: <u>Catoline Hager</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Joseph Taylor, Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | <u>Coronary Thrombosis</u> | |
| IMMEDIATE CAUSE (A) <u>Myocardial Failure</u> | | <u>12 hrs</u> | |
| ANTECEDENT CAUSE (B) <u>Atherosclerosis</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Davages of Age</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>—</u> | | 19B. MAJOR FINDINGS OF OPERATION: <u>—</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u> M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? <u>—</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>4/11/55</u> , to <u>4/14/55</u> , that I last saw the deceased <u>4/14/55</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE OF REGISTRAR: <u>[Signature]</u> | | ADDRESS: <u>M. D. Cumberland</u> | |
| DATE SIGNED: <u>4/15/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u> | | DATE THEREOF: <u>April 17, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY: <u>Fort Ashby Cemetery</u> | | LOCATION (City, town, or county) (State): <u>Fort Ashby, W. Va.</u> | |
| 24. FUNERAL DIRECTOR: <u>Charles L. George</u> | | ADDRESS: <u>Cumberland, Md.</u> | |



Within corporate limits

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03267

3270

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>Cumberland, Md.</u> | | <u>1 Day</u> | | OR TOWN <u>Cumberland, Md.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>Memorial Hospital</u> | | | | <u>7 Offutt St.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) | | (Middle) | | (Last) | |
| <u>Baby</u> | | <u>Girl</u> | | <u>Ruppenkamp</u> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <u>Female</u> | | <u>White</u> | | <u>Single</u> | | <u>April 25, 1955</u> | |
| 9. AGE last birthday | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| | | Months | | Days | | Hours | |
| | | <u>1</u> | | <u>1</u> | | <u>1</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY | |
| <u>None</u> | | | | <u>Cumberland, Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>John R. Ruppenkamp</u> | | | | <u>Catherine D. Sharon</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| <u>No</u> | | | | <u>None</u> | | | |
| 17. INFORMANT & ADDRESS: | | | | | | | |
| <u>Memorial Hospital</u> | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) | | | | | | <u>32 hrs</u> | |
| <u>Atelectasis</u> | | | | | | | |
| ANTECEDENT CAUSE (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | <u>Prematurity</u> | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| <u>25 April, 1955</u> | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| OF INJURY | | at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>25 April, 1955</u> to <u>26 April, 1955</u> , that I last saw the deceased alive on <u>26 April, 1955</u> , and that death occurred at <u>4:55 P.M.</u> on the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>Edward A. Ransom</u> | | | | <u>26 April</u> | | | |
| M.D. <u>63 Green St</u> | | | | <u>Cumberland, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>April 27, 1955</u> | | <u>St. Marie Cemetery</u> | | <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>April 27, 1955</u> | | <u>Winter R. Franz, M.D.</u> | | <u>James F. Scarpelli</u> | | <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2045212402
VS. A15 — 10 - 53

BUREAU V. S.

MAY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03268

3271

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|--------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>Cumberland</u> | <u>2 days</u> | TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>Sacred Heart Hospital</u> | | <u>501 Warren St.</u> | |
| 3. NAME OF DECEASED. | | 4. DATE (Month) (Day) (Year) | |
| (Type or Print) <u>Peter Santora</u> | | OF DEATH: <u>4/24/55</u> | <u>19</u> |
| 5. SEX. <u>M</u> | 6. COLOR OR RACE. <u>W</u> | 7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify) | 8. DATE OF BIRTH. <u>6-29-78</u> |
| 9. AGE last birthday <u>76</u> yrs | | 10. AGE last birthday (If UNDER 1 YEAR) (If UNDER 24 HRS.) | |
| | | Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY. <u>Grocery</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Italy, Ascoli-Satriano</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME: <u>Andrew Santora</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mary Jo Salatta</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-05-5833</u> | |
| 17. INFORMANT & ADDRESS: <u>Mr. Andrew F. Santora Balto. Pike, Cumb.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE <u>430.0</u> | | <u>Uremia</u> | |
| ANTECEDENT CAUSE (8) | | <u>3 weeks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | <u>2 yrs</u> | |
| (A) <u>Arteriosclerosis Heart Disease</u> | | | |
| (B) <u>Arteriosclerosis Heart Disease</u> | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>10-8</u> , 19 <u>54</u> , to <u>4-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>55</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Roger W. Baccin</u> | | ADDRESS <u>Cumberland Md</u> | |
| DATE SIGNED <u>4-25-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/27/55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Pauls Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 26, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Hanby M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>H. Wayne George</u> | | ADDRESS <u>Cumberland, Md.</u> | |

U. S. A.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3286

CERTIFICATE OF DEATH

Reg. Dist. No.

03269

9

| | | | |
|--|--------------------------------|--|-------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>Frostburg</u> | <u>4 days</u> | TOWN <u>Route 1, Frostburg</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>Miner's Hospital</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>James H. Scott</u> | | OF DEATH <u>April 30th, 1955</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| <u>Male</u> | <u>White</u> | <u>Widower</u> | <u>August 7th, 1879</u> |
| 9. AGE last birthday | | 10. BIRTHPLACE (State or foreign country) | |
| <u>75 yrs</u> | | <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| <u>Adam Scott</u> | | <u>Jane Nicols</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| <u>No</u> | | <u>214-05-9909</u> | |
| 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| <u>Percy Scott, Route 1, Frostburg, Md.</u> | | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | |
| | | IMMEDIATE CAUSE (A) <u>Uremia</u> | |
| | | ANTECEDENT CAUSE (B) <u>Cardio-vascular Renal disease</u> | |
| | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | |
| | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| | | <u>Several years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>March, 1953</u> , to <u>April 30, 1955</u> , that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>1:30 A</u> M. from the causes and on the date stated above. | | | |
| SIGNATURE | | DATE SIGNED | |
| <u>John B. Davis, M.D.</u> | | <u>5/2/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| <u>Burial</u> | | <u>May 2nd, 55</u> | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Vale Summit Cemetery</u> | | <u>Vale Summit, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | 24. FUNERAL DIRECTOR ADDRESS | |
| <u>5-2-55</u> | | <u>Joseph R. Durst, Frostburg, Md.</u> | |

1944



1944

1944

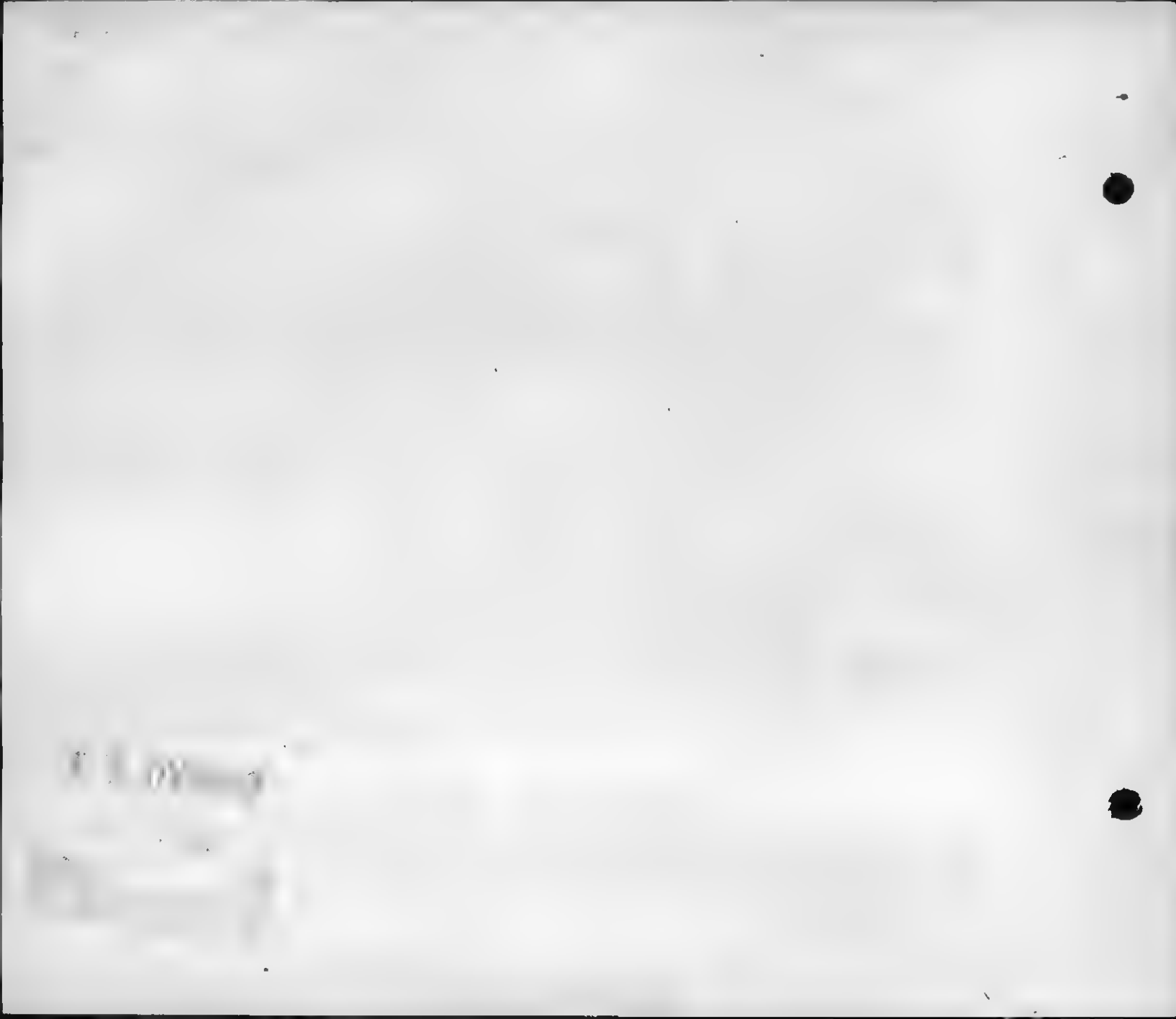
3272 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH. | | 2. USUAL RESIDENCE (HOME) OF DECEASED. | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL) <u>Cumberland</u> | LENGTH OF STAY (in this place) <u>57 years</u> | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | OR TOWN |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>803. Columbia Ave</u> | | STREET ADDRESS (If rural give location) <u>803. Columbia Ave</u> | |
| 3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>H</u> (Last) <u>Smith</u> | | 4. DATE (Month) (Day) (Year) OF DEATH. <u>April 21 1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> | 8. DATE OF BIRTH: <u>October 23 1897</u> |
| 9. AGE last birthday: <u>57</u> yrs. | | 10. AGE last birthday: <u>57</u> yrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Western Maryland RR.</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Charles J. Smith</u> | | 14. MOTHER'S MAIDEN NAME: <u>Anna Lowery</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO: <u>705-10-7825</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Olive Smith, Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Carcinomatosis</u> | | | |
| ANTECEDENT CAUSE (B) <u>Carcinoma of right lung</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc. | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 1954</u> , to <u>Apr. 21, 1955</u> , that I last saw the deceased alive on <u>Apr. 20, 1955</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 24 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> | | LOCATION (City, town, or county) (State) <u>Cumberland Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 24, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>William H. Kight</u> | | ADDRESS <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3273 CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|---|--|------------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | LENGTH OF STAY (in this place) <u>12/6/51</u> | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> | <u>22</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u> | | STREET ADDRESS (If rural give location) <u>158 West Main Street</u> | <u>1</u> |
| 3. NAME OF DECEASED: (First) <u>Lavina</u> (Middle) (Last) <u>Spitznas</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April 25, 1955</u> | |
| 5. SEX. <u>Female</u> | 6. COLOR OR RACE. <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH. <u>10/9/1870</u> |
| 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. <u>84</u> yrs. Months Days Hours Mln. | | 10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Housework</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Henry Spitznas</u> | | 14. MOTHER'S MAIDEN NAME: <u>Catherine Doubt</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Allegany County Infirmary Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u> | | | |
| ANTECEDENT CAUSE (B) <u>Cerebral arteriosclerosis</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Chronic Hepatitis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Infection</u> | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 2, 1952</u> to <u>Apr 25, 1955</u> ; that I last saw the deceased alive on <u>Apr. 24, 1955</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Jacob Hafer</u> | | M.D. <u>44 Green St.</u> | |
| DATE SIGNED <u>4-25-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/28/55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u> | | LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 26, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Tautz, M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>Jacob Hafer</u> | | ADDRESS <u>Frostburg, Maryland</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DOMINANT

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03272

3287 CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|--|--------------------------------------|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>22 Frostburg</u> | | LENGTH OF STAY (in this place) <u>5yrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town Frostburg</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>183 W. Mechanic Street</u> | | | | STREET ADDRESS (If rural give location) <u>183 W. Mechanic St.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mary Leona Stapleton</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>14</u> <u>19</u> <u>55.</u> | | | |
| 5. SEX. <u>F</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>9-22-1883</u> | 9. AGE last birthday <u>71</u> yrs. | IF UNDER 1 YEAR Months <u></u> | IF UNDER 24 HRS. Days <u></u> | Hours <u></u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Treasury Dept. U.S. Government</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Vale Summit, Md.</u> | | 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Thomas Stapleton</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Margaret Delaney</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u> | | | | 17. INFORMANT & ADDRESS: <u>Bernadette Finn, 183 W. Mechanic St.</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 420.1 IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. | | | | (A) DUE TO <u>Coronary Occlusion</u> | | <u>Sudden</u> | |
| | | | | (B) DUE TO <u>Coronary Sclerosis</u> | | <u>1 mo?</u> | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Mar 22</u> , 19 <u>55</u> , to <u>Apr 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 26</u> , 19 <u>55</u> , and that death occurred at <u>8:10 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wm. H. Lane</u> | | | | ADDRESS <u>Frostburg Md</u> | | DATE SIGNED <u>Apr 15 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | DATE THEREOF <u>4-16-55</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Michael's Catholic</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4-16-55</u> | | | | REGISTRAR'S SIGNATURE <u>Wm. H. Lane</u> | | 24. FUNERAL DIRECTOR <u>Jacob Hafer, 23 E. Main, Frostburg, Md.</u> | |

100000

221

00

31

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03273

3293

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Cumberland, Rural</u> | | 82 Years | | OR TOWN <u>Cumberland, Rural</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2, Baltimore Pike</u> | | | | STREET ADDRESS (If rural give location) <u>Route 2, Baltimore Pike</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| X ELIZABETH M. STEGMAIER | | | | DEATH: April 17, 1955 19 | | | |
| 5. SEX: Female | | 6. COLOR OR RACE: White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED: Single | | 8. DATE OF BIRTH: Aug. 14, 1872 | |
| 9. AGE last birthday: 82 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY: Own home | | 9. AGE last birthday: 82 yrs | |
| 11. BIRTHPLACE (State or foreign country): Cumberland, Md. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME: Leonard Stegmaier | | | | 14. MOTHER'S MAIDEN NAME: Gertrude Hook | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT & ADDRESS: Anna Stegmaier, Cumberland, Md. | | | | 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Cardiac Failure</u> | | | | 3 days | | | |
| ANTECEDENT CAUSE (B) <u>Hypertensive Cardio-Vascular Disease</u> | | | | 5 yrs | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>malnutrition</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>none</u> | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. 1953, to 17 April 1955, that I last saw the deceased alive on 13 April, 1955, and that death occurred at 8:40 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James S. Stegmaier</u> | | | | M.D. ADDRESS DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | April 20 1955 | | St. Peter & Pauls Cem. | | Cumberland, Md. | |
| DATE REC'D BY LOCAL REGISTRAR: April 20, 1955 | | | | REGISTRAR'S SIGNATURE: <u>Walter R. Frank, M.D.</u> | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| William H. Kight, Cumberland, Md. | | | | | | | |

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

37.1.8

U. S. S.

1955

1955

3274

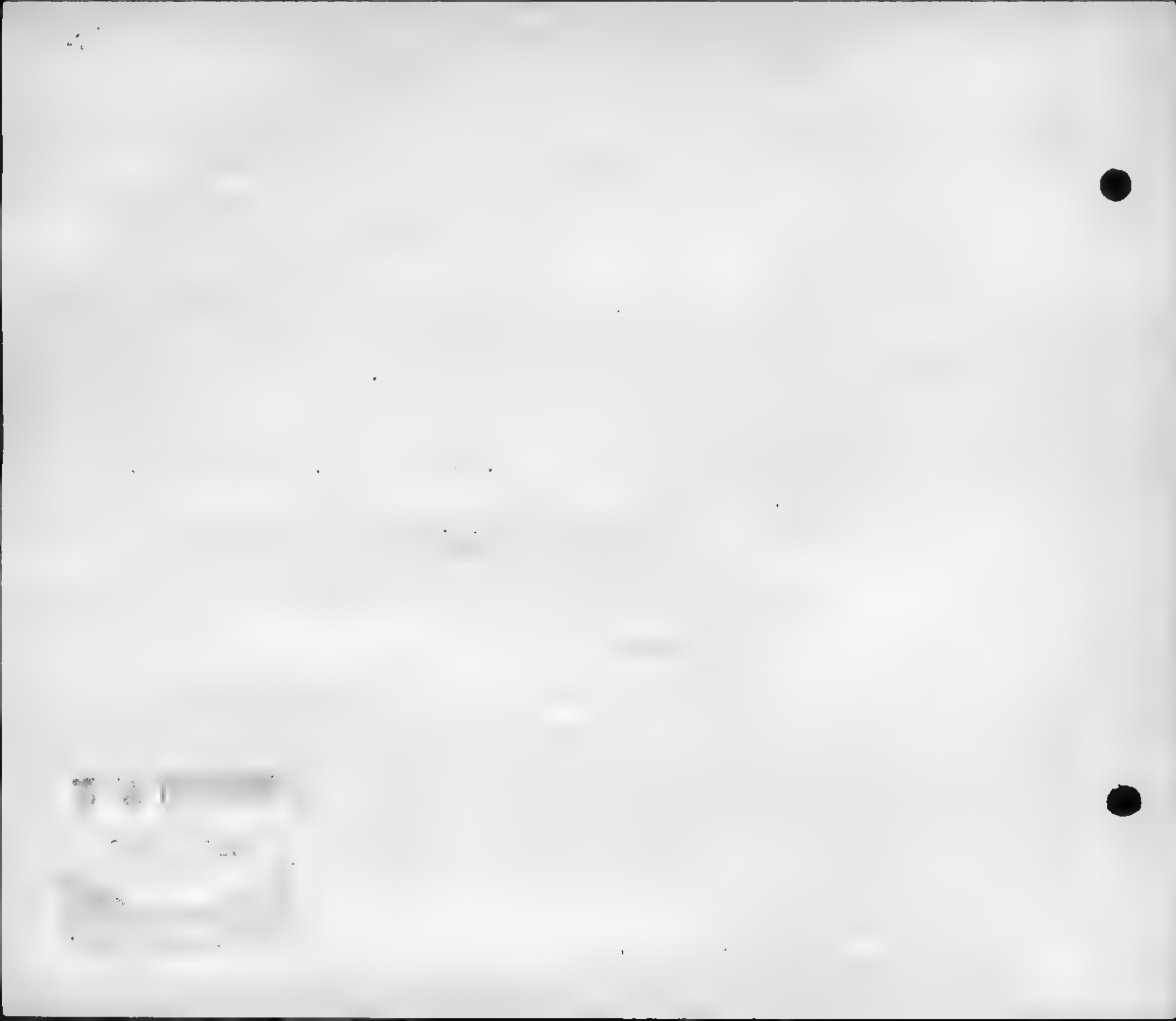
CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|------------------|--|-------------------------|--|-----------------|---|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| TOWN <u>Cumberland</u> | | <u>12 hours</u> | | TOWN <u>Cumberland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u> | | | | STREET ADDRESS <u>Washington Lee Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>ANN STRICKLAND</u> | | | | OF DEATH: <u>April 7</u> <u>19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>September 5 1889</u> | <u>65</u> yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Own Home</u> | | <u>Renova, Pa.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME: <u>Daniel Healy</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS: <u>F. C. Strickland, Cumberland, Md.</u> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 30 | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Heart failure</u> | | | | | | | |
| ANTECEDENT CAUSE (B) <u>malnutrition</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>arteriosclerosis</u> | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>April 1, 1955</u> to <u>April 7, 1955</u> , that I last saw the deceased alive on <u>April 2, 1955</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. M. Strickland</u> | | | | DATE SIGNED <u>April 7, 1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | M. D. | | | |
| <u>Burial</u> | | | | | | | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>April 7, 1955</u> | | <u>Walter R. Mautz, M.D.</u> | | <u>William H. Kight, Cumberland, Md.</u> | | | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| DR. SCHINDLER MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03275 3275 | | | | | | | | | |
|---|--|---|--|---|---|--|--|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 4 | | | | | | | | | |
| 1. PLACE OF DEATH: | | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | | |
| COUNTY ALLEGANY MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND LENGTH OF STAY (in this place) 27 DAYS HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | | | | | STATE MARYLAND COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND STREET ADDRESS (If rural give location) 26 GREENE STREET | | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) MAUDE SUTTON | | | | | 4. DATE (Month) (Day) (Year) OF DEATH: APRIL 19, 1955 | | | | |
| 5. SEX: FEMALE | | 6. COLOR OR RACE: WHITE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED | | 8. DATE OF BIRTH: FEB. 10, 1890 | | 9. AGE last birthday 65 yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner | | 10B. KIND OF BUSINESS OR INDUSTRY: Restaurant | | 11. BIRTHPLACE (State or foreign country): ENGLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME: CHARLES CONDOUR | | | | | 14. MOTHER'S MAIDEN NAME: CLARA, (Unknown) | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 156-26-6914 | | 17. INFORMANT & ADDRESS: Memorial Hosp. Cumberland Md. | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) Cerebral Embolism | | | | | | | | 10 days | |
| ANTECEDENT CAUSE (B) Arterial Thrombosis | | | | | | | | weeks | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) arteriosclerotic Heart Disease | | | | | | | | years? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | | | |
| 19A. DATE OF OPERATION: | | | | | 19B. MAJOR FINDINGS OF OPERATION | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from March 15, 1955 to April 19, 1955, that I last saw the deceased alive on April 9, 1955, and that death occurred at 3:55 PM, from the causes and on the date stated above. | | | | | | | | | |
| SIGNATURE B. M. Schindler | | | ADDRESS M. D. 41 Greene St | | | DATE SIGNED 4/24/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | DATE THEREOF 4-22-1955 | | | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | | | |
| | | | | | | LOCATION (City, town, or county) (State) Cumberland, Md. | | | |
| DATE REC'D BY LOCAL REGISTRAR April 22, 1955 | | | REGISTRAR'S SIGNATURE Walter R. Stang, M.D. | | | 24. FUNERAL DIRECTOR Charles L. George | | | |
| | | | | | | ADDRESS Cumberland, Md. | | | |

RECEIVED
APR 1 1964
BUREAU V. S.

3276

CERTIFICATE OF DEATH

Reg. Dist. No. 7

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH. | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> LENGTH OF STAY (in this place) <u>51 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lonaconing</u> <u>Maryland</u> STREET ADDRESS (If rural give location) <u>1</u> | |
| 3. NAME OF DECEASED: (Type or Print) <u>John Wm. Sweitzer, Jr.</u> | | 4. DATE OF DEATH <u>4-17-55</u> 19 <u>55</u> | |
| 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH: <u>12-16-1868</u> 9. AGE last birthday, IF UNDER 1 YEAR, IF UNDER 24 HRS. <u>86</u> yrs Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <u>Coal Mine</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland -Orleans</u> | |
| 13. FATHER'S NAME: <u>John Wm. Sweitzer</u> | | 14. MOTHER'S MAIDEN NAME <u>Shirlett Kear</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>7220-10-2576</u> | |
| 17. INFORMANT & ADDRESS <u>Mrs. Hattie Sweitzer</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>severe thrombosis</u> | | <u>48</u> | |
| ANTECEDENT CAUSE (S) (B) <u>metastatic carcinoma</u> | | <u>6 mo</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of the Prostate</u> | | <u>1-2 years</u> | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21F. HOW DID INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from <u>1-12</u> , 19 <u>55</u> , to <u>4-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>John W. Sweitzer, Jr.</u> | | DATE SIGNED <u>4-17-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | NAME OF CEMETERY OR CREMATORY <u>David Memorial</u> | |
| DATE THEREOF <u>4-21-55</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 18, 1955</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>James F. Scarielli, Cumberland, Md.</u> | |
| REGISTRAR'S SIGNATURE <u>Walter R. Stantz, M.D.</u> | | | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 A

3277
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

02 TOWN Cumberland

LENGTH OF STAY (in this place)

19 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

703 Louisiana Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Cumberland

STREET ADDRESS (If rural, give location)

703 Louisiana Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Joseph

Francis

Tippen

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

Feb. 27, 1905

4. DATE OF DEATH:

(Month)

(Day)

(Year)

4 20

19 55

9. AGE last birthday:

50

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Supervisor

10b. KIND OF BUSINESS OR INDUSTRY:

Textile Mill

11. BIRTHPLACE (State or foreign country):

Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

16. SOCIAL SECURITY No.:

217-10-5521

17. INFORMANT & ADDRESS:

Mrs. Helen Tippen, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

241X

Immediate cause

(a) DUE TO

Coronary occlusion

Antecedent cause(s)

(b) DUE TO

Hypertensive Heart Disease

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c) DUE TO

chronic asthmatic bronchitis

INTERVAL BETWEEN ONSET AND DEATH

18 years

15 years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

none

PLACE (Home, farm, factory, street, office bldg., etc.)

OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY

none

INJURY OCCURRED

While at work

Not while at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 3, 1955 to APR. 30, 1955, that I last saw the deceased alive on 4-20-55, 19....., and that death occurred at 6:35 P.M., from the causes and on the date stated above.

SIGNATURE

J. Hallinan M.D.

(DEGREE OR TITLE)

140 S. Cumberland St. Md.

DATE SIGNED

4-27-55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

4-25-1955

NAME OF CEMETERY OR CREMATORY

St. Mary's

LOCATION (City, town, or county)

Cumberland, Md.

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

April 24, 1955 Walter R. Darg, M.D.

24. FUNERAL DIRECTOR

James F. Scarpelli, Cumberland, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



EDMUND

1000



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03278
3278
CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|-------------------|--|-------------------|--|-----------------|---|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>Cumberland</u> | | <u>13 hrs.</u> | | OR TOWN <u>Cumberland, rural</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>R.F.D. #3. Bedford Road</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH: (Month) (Day) (Year) | | | |
| <u>William E. Thom</u> | | | | <u>4-29-55</u> <u>19</u> | | | |
| 5. SEX. | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>M</u> | <u>W</u> | <u>Married</u> | <u>5-9-93</u> | <u>61</u> yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Mechanist</u> | | | | <u>B. & O. RR</u> | | <u>Maryland</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Robert Thom</u> | | | | <u>Margaret McBride</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S ADDRESS: | |
| <u>YES</u> | | | | <u>705-05-4819</u> | | <u>Mrs. Helen Thom</u> <u>Route 3, Cumberland, Md.</u> <u>Wife</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Bronchial Obstruction</u> | | | | | | <u>3 weeks</u> | |
| ANTECEDENT CAUSE (S) (B) <u>Carcinomatous of Bronchial nodes</u> | | | | | | <u>1 year</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of Lung - right</u> | | | | | | <u>1 year</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Post operative emphysema - right</u> | | | | | | <u>1 year</u> | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? | |
| <u>1954</u> | | <u>Carcinoma Right Lung with lymph node metastasis</u> | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, etc.) OF INJURY | | 21C. WHERE DID INJURY OCCUR? | | (County) (State) | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from: <u>1951</u> , to <u>April 29 1955</u> , that I last saw the deceased alive on <u>April 28, 1955</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS | | DATE SIGNED | | | |
| <u>Theresa M. M. D.</u> | | <u>Cumberland</u> | | <u>Apr 29/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>May 1 1955</u> | | <u>Zion Memorial Burial Park</u> | | <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>May 1, 1955</u> | | <u>Walter L. Gantz, M.D.</u> | | <u>William H. Kight, Cumberland, Md.</u> | | | |

ROBERT V. S.

May 5 1965



Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3294

CERTIFICATE OF DEATH

03279

Reg. Dist. No.

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Allegany</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| X TOWN <u>Rural Cumberland</u> | | OR TOWN <u>Rural Cumberland</u> | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. # 4. Oldtown Road</u> | | STREET ADDRESS (If rural give location) | <u>Rt. # 4. Oldtown Road</u> |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>Ehrman Elizabeth Twigg</u> | | DATE OF DEATH: <u>Apr. 10, 1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u> | 8. DATE OF BIRTH: <u>Jan. 11, 1866</u> |
| 9. AGE last birthday <u>89</u> yrs | | 10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John D. Ellis</u> | | 14. MOTHER'S MAIDEN NAME <u>Theodocia Turner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Ira Robinette Cumberland, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> | | | |
| ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular Disease</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. HOW DID INJURY OCCUR? | |
| 21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY | | 21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 22. I hereby certify that I attended the deceased from <u>Nov, 1954</u> , to <u>April, 1955</u> , that I last saw the deceased alive on <u>March 30, 1955</u> , and that death occurred at <u>130/p M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Walter R. Hantz, M.D.</u> | | DATE SIGNED <u>April 12, 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4-13-1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cem.</u> | | LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 12, 1955</u> | | 24. FUNERAL DIRECTOR <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03280

3295

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH- COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Allegany | |
| CITY (If outside corporate limits, write RURAL and give nearest town) McCool | | CITY (If outside corporate limits, write RURAL and give nearest town) McCool | |
| TOWN McCool | | TOWN McCool | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Westernport Road | | STREET ADDRESS (If rural, give location) Westernport Road | |
| 3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Ervin (Last) Weasenforth | | 4. DATE OF DEATH (Month) Apr. (Day) 9 (Year) 1955 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 25, 1883 |
| 9. AGE last birthday 71 yrs. | | 10. If under 1 year: Months 1 Days 19 If under 24 hrs. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Scheer, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Theodore Weasenforth | | 14. MOTHER'S MAIDEN NAME Catherine Amtower, | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS Charles Ray Weasenforth | | | |

| | | | | | |
|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1a. Immediate cause (a) Carcinoma of lungs (metastatic) | | | | Jan 1955 | |
| Antecedent cause(s) (b) Nephroma - right | | | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT (Specify) SUICIDE | | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY m. | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan , 1955, to April 9 , 1955, that I last saw the deceased alive on April 9 , 1955, and that death occurred at 1:45 P. m. , from the causes and on the date stated above. | | | | | |
| SIGNATURE D. Giffen MD | | ADDRESS Heper WA | | DATE SIGNED 4-9-55 | |
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | | DATE 4/12/55 | | NAME OF CEMETERY OR CREMATORY Dayton Cemetery | |
| LOCATION (City, town, or county) Near McCool | | (State) Md. | | | |
| DATE REC'D BY LOCAL REG. 4-11-55 | | REGISTRAR'S SIGNATURE Mrs Jean C. Kelly | | 24. FUNERAL DIRECTOR Brown & Woodward | |
| | | | | ADDRESS Kenner, W. Va | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1955

1955

1955

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|--|--|--|----------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Allegany</u> | MARYLAND | STATE <u>Maryland</u> COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | LENGTH OF STAY (in this place) <u>Life</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hosp</u> | | STREET ADDRESS (If rural give location) <u>314 Frederick St</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| <u>Leonard Van Wheeler</u> | | OF DEATH: <u>April 30 1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Caucasian</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>4/29/55</u> |
| 9. AGE last birthday: <u>1</u> yrs. <u>1</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Alfred Wheeler</u> | | 14. MOTHER'S MAIDEN NAME: <u>Bessie Taylor</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Sacred Heart Hospital</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Mal presmith Break with Fat</u> | | <u>39 hrs</u> | |
| ANTECEDENT CAUSE (B) <u>Hydramnios</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Small baby 4.66 30g</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Difficult labor, Slow labor 24 hrs</u> | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>april 29 1955</u> , to <u>april 30 1955</u> that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>10 P M</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>F. L. G. Murray</u> | | M. D. <u>Cumberland Md</u> DATE SIGNED <u>May 1-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5/2/55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>May 2, 1955</u> | | REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>Louis Stein, Inc</u> | | ADDRESS <u>Cumberland, Md</u> | |

204-5364392

WOMAN V. S.

MAY 5 1955

RECEIVED

3280

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY ALLEGANY | MARYLAND | STATE PENNA. | COUNTY Bedford |
| CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND | LENGTH OF STAY (in this place) 3 HR. 6 MIN. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BREEZEWOOD 75X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL | | STREET ADDRESS (If rural give location) ✓ | |
| 3. NAME OF DECEASED: (Type or Print) Jeffery Lynn (Middle) WILT - Linn (Last) | | 4. DATE (Month) (Day) (Year) OF DEATH: APR. 29 1955 | |
| 5. SEX: MALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE | 8. DATE OF BIRTH: APRIL 29, 1955 |
| 9. AGE last birthday 3 yrs. 6 Months 3 Days 6 Hours 6 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | |
| 11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: VICTOR D. WILT | | 14. MOTHER'S MAIDEN NAME: NORMA JEAN WINTER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) Prematurity - 2nd of twins | | | |
| ANTECEDENT CAUSE (B) Repeat section - active labor at 7 1/2 months | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) atelectasis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 4/28, 1955 to 4/28, 1955 , that I last saw the deceased alive on 4/28, 1955 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE W.R. Royce Hodges | | ADDRESS Cumberland, Md. DATE SIGNED 4/28/55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 4/30/1955 | |
| NAME OF CEMETERY OR CREMATORY Wt. Zion Lutheran | | LOCATION (City, town, or county) (State) E. Providence, Twp., Bed Co., Pa. | |
| DATE REC'D BY LOCAL REGISTRAR April 29, 1955 | | REGISTRAR'S SIGNATURE Walter R. Brant, M.D. | |
| 24. FUNERAL DIRECTOR Lynnford V. Coomer | | ADDRESS Everett, Pa. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03283

3281

CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Allegany</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Allegany</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| <u>022</u> <u>Cumberland</u> | | <u>2 days 19 hrs.</u> | | <u>022</u> <u>Cumberland</u> <u>Rural</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>42</u> <u>Sacred Heart Hospital</u> | | | | <u>R.F.D. #3, Bedford Road</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE (Month) (Day) (Year) | | | |
| (First) (Middle) (Last) | | | | OF DEATH: <u>4-28-55</u> <u>19</u> | | | |
| <u>Iva Margaret Zufall</u> | | | | | | | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH: | |
| <u>F</u> | | <u>W</u> | | <u>Married</u> | | <u>4-21-9D</u> | |
| 9. AGE last birthday | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| <u>64</u> yrs. | | Months Days | | Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Housewife</u> | | | | <u>Own Home</u> | | <u>Shanesville, West Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME: | | | |
| <u>U.S.A.</u> | | | | <u>Hyle Bennett</u> | | | |
| 14. MOTHER'S MAIDEN NAME: | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | |
| <u>Minnie Edwards</u> | | | | <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT & ADDRESS: | | | |
| <u>None</u> | | | | <u>Peter Zufall, Rt. 3, Cumberland, Md</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u> | | | | | | <u>4 days</u> | |
| ANTECEDENT CAUSE (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (260X) (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | <u>1 year</u> | |
| <u>Diabetes mellitus</u> | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>4-25</u> , 19 <u>55</u> , to <u>4-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>55</u> , and that death occurred at <u>11:09 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Ray L. Baccin</u> | | | | DATE SIGNED <u>4-29-55</u> | | | |
| M. D. <u>Cumberland Md</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Apr. 30, 55</u> | | <u>Zion Memorial Park</u> | | <u>Cumberland, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>April 29, 1955</u> | | <u>Walter R. Trantz, M.D.</u> | | <u>John J. Hafer, Cumberland, Md.</u> | | | |

RECEIVED
MAY 3 1955
BUREAU V. S.

Shaw